

ANGLIA RUSKIN UNIVERSITY

A FEASIBILITY TRIAL OF
GROUP COGNITIVE ANALYTIC MUSIC THERAPY
IN SECURE HOSPITAL SETTINGS

STELLA COMPTON DICKINSON

A thesis in partial fulfilment of the
requirements of Anglia Ruskin University
for the degree of Doctor of Philosophy

Submitted: November 2014

Acknowledgements

Thanks are due firstly for invaluable support from Professor Helen Odell-Miller who has supervised the present study since January 2011 at Anglia Ruskin University. Prior to this, Helen was the external supervisor during the MPhil to PhD upgrade that was registered at King's College London, the Institute of Psychiatry. Helen supported and advised me towards the development of the research treatment manual and she has provided all the qualitative research supervision. Her encouragement and excitement about this study helped me to sustain my motivation through many operational and personal adversities.

During and prior to PhD registration at Anglia Ruskin University, Professor Paul Mc Crone supervised, guided and monitored operational and academic development, always providing clear advice. Paul has been a source of consistent support since I registered at the Institute of Psychiatry where Dr Sarah Byford also provided wise advice as Personal Tutor. Through the Centre for the Economics of Mental and Physical Health (CEMPH), Paul enabled me to attend Forensic Mental Health Science seminars and lectures so that I could develop research skills. I received rigorous scientific critique from Professor Tom Fahy, who directed me to follow the MRC research guidance. This followed from initial research supervision with Professor Richard Grey.

When commencing PhD studies at Anglia Ruskin University, Dr Gill McGauley, Reader and Consultant in Forensic Psychotherapy at St Georges University of London, advised on the methodology. Her skills and experience of research in high secure hospital settings and her knowledge of the ethical implications when treating patients who have limited choice, were invaluable towards developing the present study research protocol. Gill advised on the ethical approval application process, on which both Helen and Paul also gave helpful advice. Gill has been positive, encouraging and generous. Preliminary consultations at the research site took place with Professor Mary McMurran, subsequent consultations before, during and after the implementation took place with Dr Michael Ferriter and Dr John Milton, both of whom supported the chosen methodology and helped to ensure that ethical procedures were followed.

The implementation of the present study was made possible by a two year ‘Invest to Innovate’ grant awarded by Nottinghamshire Healthcare NHS Trust. Most importantly of all, thanks goes to all those who made up the research team. Music therapists Victoria Sleight and Claire Newman for their skilled, sensitive and robust delivery of the treatment. Dr Chris Beeley, the Senior Evaluation Manager, Staff Nurse Kathryn Sharpe and members of the arts therapies team who helped Kathryn to administer the outcome measures. Michael Knight oversaw my clinical supervision of the music therapists to ensure adherence to the cognitive analytic model. Implementation involved the approval and support of ward managers, team leaders and nursing staff towards enabling patients to attend the treatment groups. Nursing staff were actively involved in completing the observational measurement tool. Administrative staff in the Therapies and Education Department transcribed the data from semi-structured interviews. Lead Psychologists David McMahon and Dr Andy Benn were central in supporting and facilitating the delivery of the pilot project and the present study respectively. Thanks also to Forensic Psychologist, Rebecca Lawday from whom I learnt a lot in the pilot project. Since the ending of my post in the National Health Service, this study would not have reached completion without the invaluable dialogue and reflective thinking undertaken with my assistant Marta Linkmeyer Gabino.

Last and by no means least, I thank my special friends and relations for their understanding during my many hours of writing. They have been a vital source of nourishment. My physical trainers Paul and Jason have helped me to develop extreme self-discipline and to stay physically and mentally strong, despite my impairments. In particular I thank my Mother for her constant and unshakeable faith in my abilities. Many helpful comments on some chapters from a music therapist who claims to have very limited knowledge of forensic psychiatry have helped to keep my spirits up in times of adversity.

The study is dedicated to my most loyal companions throughout this project:
Phinak and Jaadu.

Abstract

There are no large-scale outcome studies of music therapy in secure hospital settings for people who have committed serious offences. These patients have a right to expect evidence-based multi-disciplinary treatment (Duggan et al. 2006); NICE (2010). Music therapy therefore should take a form which can be integrated into the treatment pathway.

A single site implementation of a mixed-methods patient preference randomised controlled trial investigated the clinical effectiveness of a manualised music therapy model called Group Cognitive Analytic Music Therapy (G-CAMT). This context-specific, time limited intervention incorporates theories from Group Analysis (Foulkes 1964) and Cognitive Analytic Therapy (Ryle and Kerr 2003). The central research question was ‘Is G-CAMT feasible and effective for offenders in a secure multi-disciplinary treatment setting?’

The research process followed the Medical Research Council framework for developing and evaluating complex interventions (Campbell et al. 2000, 2007). Twenty patients were recruited; those expressing no preference were randomised to treatment or control arms. The two music therapists and the principal investigator were masked to their allocation status. Those in the treatment arm were allocated to one of two treatment groups of five, each run individually by one of the music therapists. Each group had sixteen ninety minute weekly sessions with follow-up at eight weeks. Treatment and control groups received standard care.

The primary measure was the Person’s Relating to Others Questionnaire (Birtchnell and Evans 2004) Secondary measures were the Basic Empathy Scale (Jolliffe and Farrington 2006a), The Multi-Scale Dissociation Inventory (Briere, 2002) and an observational measure, the Chart of Interpersonal Reactions in Closed Living Environments (Blackburn and Glasgow, 1993). Quantitative data from these measures were examined for associations with qualitative data from semi-structured interviews administered to the music therapists and analyzed using Interpretative Phenomenological Analysis (Smith et.al. 2009)

Findings from the results of the primary measure demonstrated statistically significant (Mann Whitney U: $p < .05$) reductions in favour of the treatment group compared to the control, in intrusive, restrictive and possessive behaviors and helpless or self-denigrating behaviours. There were improvements over time within the treatment group in the domains of sociability and hostility (Friedman Test : $p < .04$). The use of a manual was shown to help the music therapists manage the risk of violence without constraining their creativity. Two years after the end of the treatment 78% of treatment participants had moved to conditions of lower security over a mean period of 19 months compared with 66% of control subjects over a mean period of 25.5 months. The thesis concludes by situating G-CAMT amongst contemporary music therapy models.

Key Words Mixed methods, patient preference randomised controlled trial, group analysis, cognitive analytic therapy, music therapy, forensic psychotherapy, secure hospital treatment.

Contents

Acknowledgements	ii
Abstract	iv
Contents.....	v
List of tables	xv
List of Figures	xviii
List of Acronyms	xix
Enclosed materials:	xxi
Copyright statement.....	xxii
Chapter 1 Background.....	1
1.1.Introduction.....	1
1.2 Motivation towards research.....	5
1.3 Background to the study rationale	7
1.4 Cognitive Analytic Music Therapy.....	7
1.5 The secure hospital treatment context	8
Chapter 2 Literature Review	10
2.1 Introductory summary: the treatment context.....	11
2.2 Introduction to forensic psychotherapy.....	12
2.3 Music therapy background	15
Definitions:	15
2.4 Music therapy research	18

2.5 Systematic reviews up to 2011.....	19
2.6 Cognitive Analytic Therapy (CAT).....	22
2.7 Rationale for a context-specific model: G-CAMT.....	26
2.8 CAT theoretical underpinning of G-CAMT	28
2.9 Forensic patients and co-morbidity	29
2.10 Forensic music therapy research method and tools.....	32
2.11 Standard care and patients' needs	34
 Chapter 3 Outcome Measures	 36
3.1 What are outcomes and how do we measure them?	36
3.2 Use of outcome measures in music therapy	40
3.2.1 Satisfaction measures	40
3.2.2 Standardised evaluations of music therapy.....	41
3.3 Outcomes of interest in forensic music therapy	42
3.3.1 Why measure relational changes?	44
3.3.2 How do we measure empathy and emotional relatedness?	45
3.3.3.The person's relating to others questionnaire (PROQ2) (Appendix 3a)	47
3.3.4 Observational measurements.....	47
 Chapter 4 The Development of the Treatment Approach and of the Treatment Manual.....	 50
4.1 Why develop a research treatment manual?	50
4.1.1 The psychodynamics of the secure hospital setting.....	50
4.1.2. The importance of a treatment manual for music therapists in forensic settings	55

4.1.3 Risks to the music therapist.....	57
4.2 The music therapy approach and attachment theory.....	58
4.2.1 The clinical rationale for a specific music therapy approach and treatment manual.....	60
4.3 A manual for research	62
4.3.1 Group therapy concepts as applied in the manual.....	65
4.3.2 Pilot stages of implementation.....	66
4.3.3.Discussion of pilot 2 and implications for future treatment.....	71
4.3.4 Stages of the manual: developed from pilot 2 for the main study.....	73
Chapter 5 The Research Study Treatment Manual: User Guidelines.....	75
5.1 Introduction.....	76
5.2 The Patient Group.....	76
5.2.1 Risk Procedures.....	76
5.2.2 Information about this Patient Group.....	76
5.3 Guidance for Therapists	78
5.3.1 Mindfulness.....	78
5.3.2 Emotional regulation.....	78
5.3.3 Distress Tolerance.....	78
5.3.4 Interpersonal effectiveness	78
5.4 Principles of Group Therapy.....	79
5.5 Individual Assessments and Treatment Sessions 1–4: Mindfulness	84
5.5.1 Purpose of the Sessions:	84
5.5.2 Content and Structure of Sessions:.....	85
5.5.3 Musical instruments to use:	86

5.5.4 CAT Tool to use:.....	86
5.5.5 Homework Task:	86
5.6 Treatment Sessions 5–8: Emotional Regulation and Mindfulness	86
5.6.1 Purpose of Sessions:	86
5.6.2 Content and Structure of Session:.....	86
5.6.3 Musical Instruments to use:	87
5.6.4 CAT Tool to use:.....	88
5.6.5 Therapeutic aim and Technique:.....	88
5.6.6 Homework Task:	88
5.7 Treatment Sessions 9–12: Distress Tolerance, Emotional Regulation and Mindfulness.....	88
5.7.1 Purpose of Sessions:	88
5.7.2 Content and Structure of Session:.....	89
5.7.3 Musical instruments to use:	89
5.7.4 CAT Tool to use:.....	89
5.7.5 Therapeutic aim and Technique:.....	89
5.7.6 Homework Task:	90
5.8. Treatment Sessions 13–16: Interpersonal Effectiveness, Distress Tolerance, Emotional Regulation and Mindfulness.....	90
5.8.1 Purpose of Sessions:	90
5.8.2 Content and Structure of Session:.....	90
5.8.3 Musical Instruments to use:	90
5.8.4 CAT Tool to use:.....	90
5.8.5 Therapeutic aim and Technique:.....	91

5.8.6 Homework Task.....	91
5.8.7 Final Session: Closure	91
Chapter 6 Rationale for the Methodology of the Main Study	92
6.1 Rationale for this study.....	92
6.1.1 Attachment and therapeutic engagement.....	94
6.1.2 Mindfulness, emotional regulation, and conflict resolution in music therapy....	95
6.2 Methodology of the Main Study	99
6.3 Research question	103
6.3.1 Objectives.....	104
6.4 Experimental hypotheses:	104
6.5 METHOD	107
6.6 Ethical considerations.....	108
6.7 Sample.....	111
6.8 Inclusion and exclusion criteria	112
6.9 Power calculation to determine the sample size	113
6.10 Sampling strategies	113
6.11 Materials: Assessment Instruments	116
6.11.1 Primary Outcome Measure: PROQ2 (Birtchnell & Evans, 2004).....	117
6.11.2 Secondary Outcome Measure: The Basic Empathy Scale (BES)	121
6.11.3 Secondary Outcome Measure: The Multi-scale Dissociation Inventory (MDI) (Briere, 2002).....	121
6.11.4 Observational Rating: The Chart of Interpersonal Reactions in Closed Living Environments (CIRCLE) (Blackburn & Glasgow, 2006)	121

6.11.5 Satisfaction Measure: Attkisson & Greenfield (1994) Client Satisfaction Questionnaire-8 and Service Satisfaction Scale 30	122
6.11.6 Satisfaction Measure: Music Therapy Patient Satisfaction Questionnaire.....	122
6.11.7 Semi-structured Interviews.....	123
6.12 Procedure.....	123
6.13 Data collection.....	125
6.14 Methods of data analysis.....	125
6.14.2 Qualitative analysis:	127
Chapter 7 Results: Part 1 Demographics and Hypothesis 1	130
7.1 Introduction - demographics	131
7.1.1 Age	132
7.1.2 Ethnicity.....	133
7.1.3 Length of Stay.....	133
7.1.5 Offending history	136
7.1.5 Index Offence.....	136
7.1.6 Diagnosis	137
7.2 Standard Care.....	137
7.3. The Primary Outcome measure PROQ2.....	139
7.3.1 Descriptive Statistics	140
7.3.2 The PROQ2 Domains	146
7.3.3 Overview of treatment effects for domains of PROQ2	148
7.3.4 Treatment Effects by Group and Age.....	149
7.3.5 Treatment Effects by Group and Length of Stay	152
7.3.6 Treatment Effects by Group and Duration of Offending.....	155

7.4 H1: Secondary Outcome measure MDI: domain disengagement	158
7.4.1. Descriptive Statistics	158
7.4.2 The MDI Domain	161
7.5 H1: Observational Rating: CIRCLE.....	161
7.5.1 Descriptive Statistics	161
7.5.2 The CIRCLE domains	164
7.5.3 Treatment effects for domains of CIRCLE by Group	165
7.5.4 Treatment effect compared to age.....	167
7.5.5 Treatment effects compared with Length of Stay	169
7.5.6 Circle Treatment effects compared to Offending History	172
7.6 H1: IPA Analysis.....	174
7.6.1 IPA Triangulation PROQ2 octants ND and NC which relate to the primary hypothesis 'relating to others'	175
7.6.2. IPA Triangulation to SPSS Quantitative analysis	176
Chapter 8 Results: Part 2 Hypothesis 2 and 3	181
8.1 The secondary hypotheses (H2a).....	182
8.1.1 Descriptive Statistics: Secondary Outcome Measure Basic Empathy Scale.....	182
8.2 H2.Secondary Outcome measure. The Multiscale Dissociation Inventory (MDI) (Briere, J. 2002) domain: emotional constriction	184
8.2.1 Descriptive Statistics	184
8.3 IPA Analysis triangulated against PROQ2 octants UC, UD and LD	186
8.3.1 IPA Analysis triangulated against PROQ2 octant UC domain.....	186
8.3.2 IPA Analysis triangulated against PROQ2 octants UD Domain.....	187
8.3.3 IPA Analysis triangulated against PROQ2 octants: LD Domain,.....	188

8.4 H2. IPA Stage 5 Triangulation with primary measure PROQ2) UC, UD, LD, LC Domains.....	189
8.5 Sound-prints	193
8.5.1 What is the ‘sound-print ‘?.....	193
8.5.2 IPA Analysis of positive attributes.....	193
8.5.3 Drums (26% sound- print)	193
8.5.4 The sounding Bowl. (11%)	193
8.6 Results: Hypothesis 3 Patient Satisfaction and Feasibility of Patient preference Trial	195
8.6.1. Attkisson & Greenfield Patient Satisfaction CSQ-8UK.....	195
8.6.2 Service received. CSQ-8UK.....	195
8.6.3. Satisfaction on amount of help received. CSQ-8UK	196
8.6.4 Information, and range of choice in treatment CSQ-8UK.....	197
8.7 Patient Satisfaction Questionnaire (AMT- PSQ)	198
8.7.1 IPA Analysis of Patient Feedback.....	199
8.8 IPA Analysis triangulated against PROQ2 octants: Upper Neutral (UN domain)	200
8.9 Therapists’ Satisfaction	200
8.10 Summary.....	202
Chapter 9 Discussion and Conclusions	205
9.0 Introduction.....	205
9.1 Changes in relating: forensic settings.....	208
9.1.1 Pompous, boastful, dominating and insulting form of relating (UN).....	210

9.1.2 Intrusive, restrictive and possessive form of relating (UC)	212
9.1.3 Fear of separation and of being alone (NC)	213
9.1.4 Fear of rejection and disapproval (LC)	213
9.1.5 Helpless, shunning responsibility and self-denigrating form of relating (LN)..	216
9.1.6 Acquiescent, subservient withdrawn form of relating (LD)	216
9.1.7 Suspicious, uncommunicative and self-reliant form of relating (ND)	217
9.1.8 Sadistic, intimidating and tyrannising form of relating (UD)	218
9.1.9 Secondary measure on relating to others: disengaging (MDI)	219
9.1.10 The CIRCLE observational measure: hostile form of relating	220
9.1.11 Withdrawn form of relating.....	220
9.1.12 Sociable and sociable ways of relating.....	221
9.1.13 Relation aspects in the use of instruments.....	221
9.2 Emotional relatedness and the second hypothesis.....	222
9.2.1 Empathy.....	222
9.2.2 Cognitive empathy.....	224
9.2.3 Affective empathy.....	224
9.2.4 Emotional constriction (MDI).....	224
9.3 Satisfaction with G-CAMT	225
9.3.1 Patient satisfaction. Attkisson & Greenfield 1994).....	225
9.3.2 Therapist satisfaction.....	225
9.4 Implications for future treatment: forensic music therapy.....	225
9.4.1 The pragmatics and purpose of a manual.....	228
9.4.2 Patient preference trial	232
9.4.3 Mixed methods design.....	232

9.4.4 Supervision and training	233
9.6 Limitations and future research.....	234
9.6.1 Recruitment procedure and data collection.....	234
9.6.2 Data collection.....	236
9.6.3 Time-limited treatment modifications	238
9.6.4 Musical analysis.....	238
9.7. Future directions	239
9.7.1. Suggestions for future research in forensic and early intervention.....	239
9.7.2. The treatment pathway.....	241
9.7.3. The role of music therapy with death and spirituality.....	242
9.8 Summary of Conclusions	245
Postscript.....	247
References	247

List of tables

Table 4.1: Aspects and components (MRC Guidance, 2007) which make G-CAMT a complex intervention.....	63
Table 5.1: G-CAMT tailored for the forensic population for Pilot 2.....	81
Table 6.1: The hypotheses with selected outcome measures.....	106
Table 6.2: Patient preferences to treatment, randomization or control.....	115
Table 6.3: Measurement tools for psychological and forensic domains with measurement points.....	117
Table 7.1: Demographics by Treatment and Control Group.....	131
Table 7.2: Standard Care from assessment to Follow-up (Total 27 WEEKS).....	138
Table 7.3: Negative and positive qualities of PROQ2 domains by treatment and control across time, and between groups.....	141
Table 7.4b: Descriptive statistics of PROQ2 domains with treatment effects between pre-treatment and follow-up by treatment and control.	144
Table 7.5: Participants above and below the median by groups and age/ length of stay/ offending history.	148
Table 7.6a: Participants below the median age of 34 years in treatment and control...	149
Table 7.6b: Participants at or above the median age of 34 years in treatment and control	150
Table 7.7a: Participants below the median length of stay 4.75 years by treatment and control.	152
Table 7.7b: Participants at or above median length of stay 4.75 years and control.....	153

Table 7.8a: Participants with offending history below median 14 years by treatment and control.	155
Table 7.8b: Participants with offending history at or above median 14 years by treatment and control.....	156
Table 7.9: Domain disengagement treatment and control across time	158
Table 7.10: MDI disengagement domain mean scores by individual participants in the treatment and control groups. (A reduced score demonstrates improvement.).....	160
Table 7.12: Descriptive statistics of CIRCLE domains with treatment effects between pre-treatment and follow-up by treatment and control.	163
Table 7.13a: Participants below the median age of 34 years	166
Table 7.13b: Participants at or above the median age of years.....	167
Table 7.14a: Participants below the median length of stay of 4.75 years.....	169
Table 7.14b: Participants at or above median length of stay of 4.75 years.	170
Table 7.15a: Participants below the median duration of offending history of 14 years.	172
Table 7.15b: Participants at or above the median duration of offending history of 14 years.	173
Table 7.16: IPA analysis of emerging themes in the Neutral Distant (ND) domain. ...	175
Table 7.17: IPA analysis of emerging themes in the Neutral Close (NC) domain.	175
Table 7.18: Triangulation of the qualitative IPA analysis of the PROQ2 domains and quantitative SPSS results.	176
Table 8.1: Descriptive Statistics of the Basic Empathy Scale domains by Groups	182

and time points (Jolliffe & Farrington, 2006). (Green asterix signifies statistically significant improvement within groups at $p < .05$.)	182
Table 8.2: Treatment effects pre- and post-treatment by groups.	183
Table 8.3: Descriptive statistics of the MDI domain ‘Emotional Constriction’ by groups and time points.	184
Table 8.4: MDI Domain of Emotional Constriction	185
Table 8.5: IPA Triangulation against UC	186
Table 8.6: The semi structured interview triangulated against the PROQ2 Octants in the UD domain	187
Table 8.7: The semi-structured interview triangulated against the PROQ2 Octants in the LD domain.	188
Table 8.8: Proq2 domains, qualitative IPA (observations and experiences together), and quantitative SPSS results.	189
Table 8.9: Sound-prints chosen by participants in treatment arm.....	194
Table 8.10: Responses to Question 1. What was it that made this therapy helpful?	199
Table 8.11: Responses to Question 2. How do you think that this therapy has helped you to change?.....	199
Table 8.12: Semi-structured interviews triangulated against PROQ2 octants: Upper Neutral (UN) domain).	200
Table 8.13: PROQ2 domain Upper Neutral, and IPA analysis of Music Therapists satisfaction.....	201
Table 9.1: Overall sample	241

List of Figures

Figure 6.1: Consort diagram of the sampling strategy.....	114
Figure 6.2: The negative qualities of the PROQ2 Octant	119
Figure 6.3: The positive qualities of each octant of the PROQ2 Octant.....	119
Figure 6.4: Scores of patients versus non-patients in each of the eight PROQ2 domains. (Birtchnell and Evans 2004).....	120
Figure 7.1: Groups by Age.....	132
Figure 7.2: Individual participants by Group and Age above and below the median...	132
Figure 7.3: Groups by length of stay.....	134
Figure 7.4: Individual participants by Group and Length of Stay.	135
Figure 7.5: Individual participants by Group and Offending History.....	136
Figure 8.1: Attkisson & Greenfield Client Satisfaction Questionnaire: Q1-Q4 Patient satisfaction in domains of quality, needs met, and recommendation.....	196
Figure 8.2: Attkisson & Greenfield Client Satisfaction Questionnaire: Q5-Q8 Patient satisfaction in domains of help and acceptability of treatment.	197
Figure 8.3: Attkisson & Greenfield Client Satisfaction Questionnaire: Q9-Q11 Satisfaction with information, treatment range, and choice.....	198

List of Acronyms

AARS: Adolescent Anger Rating Scale
ASPD: Anti-Social Personality disorder
BES: Basic Empathy Scale
BDI: Beck Depression Inventory
BMJ: British Medical Journal
BPD: Borderline Personality Disorder
C: Control Group
CAT: Cognitive Analytic Therapy
CAMT: Cognitive Analytic Music Therapy
CBT: Cognitive Behavioural Therapy
CCRT: Core Conflictual Relationship Theme
CEA: Cost Effectiveness Analysis
CEMPH: Centre for the Economics of Mental and Physical Health
CIRCLE: The Chart of Interpersonal Reactions in Closed Living Environments
CORE-OM: The Clinical Outcomes Routine Evaluation - Outcome Measure
CPA: Care Programme Approach
CSQ-8UK: Client Satisfaction Questionnaire
DBT: Dialectical Behavioural Therapy
DES: Dissociative Experiences Scale
DID: Dissociative Identity Disorder
DSM-IV: Diagnostic and Statistical Manual of Mental Disorders - IV
DSPD: dangerous and severe Personality Disorder
DV: Dependent Variable
fMRI: Functional Magnetic Resonance Imaging
G-CAMT: Group Cognitive Analytic Therapy
GCC: Good Clinical Care
H1: Hypothesis 1
H2: Hypothesis 2
H3: Hypothesis 3
HAT: Helpful Aspects of Therapy
HCPC: Health and Care Professions Council

HRSD: Hamilton Rating Scales for Depression
 HTA: Health Technology Assessment
 HYPE: Helping Young People Early
 IAFP: International Association of Forensic Psychotherapists
 IAPs: Improvisation Assessment Profiles
 IPA: Interpretative Phenomenological Analysis
 IRAS: Integrated Research Application System
 IV: Independent Variable
 LC: Lower Close
 LD: Lower Distant
 LN: Lower Neutral
 LoS: length of Stay
 MDI: Multi-Scale Dissociation Inventory
 MDOs: Mentally Disordered Offenders
 MDT: Multidisciplinary Team
 MHL: Mental Health Link
 MIR: Music Improvisation Rating
 MRC: Medical Research Council
 MSSM: Multi Self-States Model
 MSU: Medium Secure Unit
 MT: Music Therapy
 MT-PSQ: Music Therapy Patient Satisfaction Questionnaire
 NC: Neutral Close
 ND: Neutral Distant
 NHS: National Health Service
 NICE: National Institute for Care Excellence
 NOS: Nursing Observation Scale
 ODE: 'Observe, Describe, Explore'
 PANSS: Positive and Negative Syndrome Symptom
 PCL SV: Psychopathy Checklist Screening Version
 PET: Positron Emission Tomography.
 PI: Principal Investigator
 PROQ2: Person's Relating to Others Questionnaire

PSQ: Personality Structure Questionnaire
PSORM: Procedural Sequence Objects Relations Model
PTC: Prison Therapeutic Community
PTSD: Post Traumatic Stress Syndrome
RCs: Responsible Clinicians
RCT: Randomised Controlled Trial
RRP: Reciprocal Role Procedure
SASB-CMP: Structural Analysis of Social Behaviour - Cyclic Maladaptive Pattern
SCED: Single Case Experimental Design
SCP: State Characterisation Procedure
SDR: Sequential Diagrammatic Reformulation
SSSD: Self – States Sequential Diagram
T: Treatment Group
TAU: Treatment as Usual
MMM: Techniques for Mindfulness and making music
TRR: Therapy Response Record
UC: Upper Close
UD: Upper Distant
UN: Upper Neutral
UKCP: United Kingdom Council for Psychotherapy
UWE: University of the West of England
WFMT: World Federation of Music Therapy
ZPD: Zone of Proximal Development

Enclosed materials:

CD ROM in front cover of library copy, containing Appendices

Copyright statement

Attention is drawn to the fact that copyright of this thesis rests with

- (i) Anglia Ruskin University for one year and thereafter with
- (ii) Stella Compton Dickinson

This copy of the thesis has been supplied on condition that anyone who consults it is bound by copyright.

This work may:

- (i) be made available for consultation within Anglia Ruskin University Library, or
- (ii) be lent to other libraries for the purpose of consultation or may be photocopied for such purposes
- (iii) be made available in Anglia Ruskin University's repository and made available on open access worldwide for non-commercial educational purposes, for an indefinite period.

Chapter 1 Background

This chapter provides an introduction to the background, context and people who are involved at the site of implementation of this research project. A brief description of the history of the asylums is given in order to provide a background to the context for the development of cognitive analytic music therapy in this hospital setting. Two key national events are referred to as significant motivational factors. These are followed by an introduction to the patient group and an introductory explanation of the background to the study rationale.

1.1.Introduction

Bartlett (2009) traces the development of the psychiatric profession and the rise and establishment of asylums in the 19th and 20th centuries. She describes how this led to a rethink of the meaning of madness and insanity with a motivation towards moral treatment rather than the prior use of untested crude drugs such as bromide, or inhumane restraint with chains and manacles. Violent brutality through a lack of understanding was commonplace in the 19th century and survived into the second half of the 20th – until the move towards community care. The term ‘black pill’ is still within the anecdotal memory of people who had professional contact with individuals who were incarcerated in one such asylum. This form of ‘treatment’ was in fact punishment: it meant physical punishment – a kicking with black shoe leather from staff.

Bartlett (ibid) states that institutionalisation of individuals became more common as moral treatment developed, though whilst incarceration was a more humane approach initially introduced by the Quakers at the York Retreat, the incarceration of vastly increased numbers of apparently insane people could not be justified. Bartlett cites Scull (1979), who maintained that many people were removed from mainstream society if they were considered as deviant, and that this was often based on discrimination of class, race and gender.

Many of those people may have been considered to be ‘different’, ‘odd’, or if autism was present but not diagnosed- misunderstood. People who lack the relational skills required to represent themselves spend many years incarcerated. One such patient, who was referred to the newly formed arts therapies department at the research site, was a man with schizophrenia who

had been incarcerated for over 20 years. He had never received any formal psychotherapeutic treatment. The impact of his prolonged duration of incarceration was on several occasions literally 'brought home' during music therapy sessions, in which this man reflected on and described places and times that the music therapist herself had known long ago.

It can be difficult for all those who are enclosed in a high secure hospital to reflect on the meaning of time and life course inside the secure perimeter, because of the slowness of daily routine and how very gradually the secure hospital regimes have changed. In this respect, the above patient recalled the days when he and other patients would scrub the corridor floors and care for the on-site farm animals, which initially made the 'asylum' relatively self-sufficient. Yet, there was also a lack of change in the daily routine over weeks and months and years with little hope of an external visit other than perhaps to the funeral of a parent.

Goffman (1961) first described the impact of institutionalised life on the minds of both staff and patients. He explained the concept of the 'total institution': being cut off entirely from mainstream society and how this can predispose an individual to lose their own sense of identity. More than 40 years later, Compton Dickinson (2003; 2004) describes the links between having a sense of community within the secure perimeter, and the conflicts and cultural issues that can lead to an offence in that community.

Having qualified as a music therapist in 1994, two events were significant motivating forces towards this author's work and research in the field of forensic music therapy. At the time of her appointment as Head of Arts Therapies in a high secure hospital, there was a higher percentage of black and ethnic minority patients in high secure hospital treatment than in the general population (Parkinson, 2002). New healthcare policy initiatives were generated at this time after two high-profile murders, one of a black man, and one committed by a black man. These both affected the public perception of violent offenders, issues of discrimination and race were raised and both cases led to public enquiries.

In April 1993 an innocent black teenager called Stephen Lawrence was killed by a group of white youths. The controversial way in which the Metropolitan police handled this crime was investigated by the Macpherson report (1999). The findings into the inquiry into Stephen's death reported institutionalised racism in the Metropolitan police force and racist motives for his murder. Institutionalized racism is a recognized factor in why a higher percentage of young black men are arrested detained and subsequently incarcerated. As a result of this murder the

Race Relations Act was amended (Department of Health 2000). This meant that public authorities were placed under a statutory duty to promote race equality.

The manslaughter in 1992 of Jonathon Zito, a white musician, by a black Caribbean man who suffered with paranoid schizophrenia, caused a public outcry about the risks and failures in the care of mentally ill people who were living in the community. The profile that this case received in the popular press was unhelpful to the perpetrator who was portrayed as a monster in racist terms. However, the victim's widow, Jane Zito, recognised that the perpetrator himself had been a victim of failed mental health services. The Zito Trust (1994) campaign was formed during the time that this author was training to be a music therapist. This campaign raised awareness of failures of mental health care and led to a review of the community care programmes thereby contributing to later changes in mental health law with the introduction of supervision orders and the Care Programme Approach (CPA).

Keating, et al. (2002) conducted a review for the Sainsbury Centre for Mental Health on how to break the circles of fear against racist attitudes. The outcomes of this review confirmed that black Caribbean patients were over-represented in mental health services, that they experienced poorer outcomes than their white counterparts and that there was cultural ignorance, stigma and anxiety associated with mental illness as well as fear of violence and prejudices, all these factors influenced risk assessments.

Keating's research highlighted that racist attitudes were apparent and that negative attitudes to racial differences prevailed but had become covert in secure hospitals generally. For this reason a managerial drive towards greater equality and diversity in the workforce at the research site of the present study, was implemented in line with the United Kingdom government policies at that time. The predominantly white local population in the rural setting of the high secure hospital in which this author was employed had little direct experience of the multi-cultural issues that prevailed in London and other major UK cities. There was a lack of understanding of the culture and needs of young black men who were admitted from inner-city areas. For these men and women there were limited treatments which engaged their interest. However, they communicated their issues through rap music. An area of interest to this author was how rap, a musical medium that is commonly used as a communicator of social injustice, could become a musically therapeutic medium.

Patients who had tried many treatments without success were referred for music therapy with a view to trying anything new that might have a positive effect. Many of the patients had lived at the hospital for many years, some had almost lost hope, others expected to live their life out and die within the high secure hospital. Indeed, it is common knowledge among the local population and nursing staff that the village church cemetery has an area dedicated to both adults and children who lived and died in the hospital.

Following the 1914 flu epidemic, this hospital admitted many children who were sent to specially built villas having suffered complications in the form of a viral assault of the brain called encephalitis lethargica. If this condition does not receive rapid treatment it can result in chaotic and challenging behaviour. One of the first referrals to the newly formed arts therapies department was an unusual case: a young, black 18-year-old man who had suffered this same viral assault to the brain. He had been committed to high secure hospital treatment because no one knew where else to send him. He had no offending history and no official 'index offence': this term refers to the precipitating major offence, which brought the individual to hospital (Ministry of Justice, 2010).

The patient referred, like the children of a hundred years ago, had behaved aggressively. Prior to admission this had frightened female nurses who perceived him as big, black and therefore dangerous. He had been incorrectly and unofficially 'labelled' as having an organic personality disorder, a diagnosis that could have meant a lifetime in secure hospital were it not for the forward-looking approach of his consultant psychiatrist who referred him. Four years of music therapy treatment followed, during which this author developed culture specific music therapy treatment incorporating rap music (Compton Dickinson and Souflas, 2012). It was through this work that much of the preliminary developmental work for the study described in this thesis was learnt empirically (Compton Dickinson, 2004; 2006).

It took a hundred years to discover that owing to plasticity of the brain – which has been observable since the introduction of functional magnetic resonance imaging (fMRI) – the after-effects of encephalitis lethargica can respond positively to music therapy. This condition was untreatable until the work of Dr Oliver Sacks (1976) in New York. He discovered that these patients could respond to certain music and could become active enough to catch a ball. With the discovery of L-dopa, a drug used for Parkinson's disease, they could come out of their catatonic state and 'awaken'. This development is portrayed in the film *Awakenings* (Columbia

Pictures), starring Robin Williams and Robert De Niro, based on Oliver Sack's 1973 book of the same title.

1.2 Motivation towards research

A high secure hospital offers opportunities to embark on research, but also presents challenges because patients are not there on fixed-term sentences. They are committed to high secure hospitals for an indefinite period of treatment until they are deemed safe enough to move to conditions of lower security. They can be motivated to engage in order to be seen to be co-operative towards this goal. The energy and caring qualities of the institution where the present research was implemented were referred to by many in the local workforce to be those of an archetypal 'mother'. Staff did not explicitly identify with paternal qualities of the institution. This is interesting when considering the staff and patient views of what it means to have, or to be, a 'mother', and how the role of the mother is central in attachment theory (Bowlby, 1988) and in psychoanalytically informed therapeutic treatment per se.

The problematic behaviours and disturbances that are common in the forensic patient group may be treated through the knowledge and application of attachment theories, which underlie both the model that this thesis describes, and the outcome measures selected as fit for purpose by which the research project has been tested.

Archetypes as described by Jung (Stevens 2006) are symbolic in understanding the hospital as an organisation, because archetypes are considered by their function (Stenudd, 2007). Wellدون (1988), in *Mother, madonna, whore: the idealization and denigration of motherhood*, explains how the mother archetype can represent many things. Similarly, these positive and negative aspects of womanhood could be played out in the organisational dynamics and projections when treating patients who have serious mental disorders who have committed violent offences.

Thus, the confined environment of the high secure hospital and all that it represents can be perceived as the feeding, containing, nurturing, soothing or devouring mother. The staff however within this environment, may be perceived as maternal or paternal figures. The impact of patients' projections on members of staff can create polarised responses. For all people who are enclosed within this secure environment, the symbolic representations of the institutional 'mother' can constantly shift, and the anxiety created can be such that splitting (Klein, 1959) occurs leading to projections of good and bad within multi-disciplinary teams

(MDTs) (Glyn, 2009; Compton Dickinson and Benn, 2012; Compton Dickinson and Gahir, 2013). The anxiety may be almost intolerable for staff if they too feel the bottomless pit of human need and desperation, or if they absorb paranoid fears about annihilating forces – the primal envy and hatred which so often underlie offence-related behaviour. Staff impulses may at worst be towards revenge, and persecutory treatment but the expected response from staff in a secure hospital is to reach out in compassion. However a compassionate response may only be possible by denying the horror of a violent offence or failing to think about it altogether, thus missing the purpose of the treatment, which is to acknowledge and reflect on the index offence thereby enabling the discovery of new meaning. This is recognised in the discussion of clinical supervision by Odell- Miller (2013). For these reasons, owing to the intimate nature of musical interaction, music therapists are at particular risk of over-involvement. Robust support, structure and clear thinking space are required through which further skills are developed.

Maguire and Merrick (2013) cite Anthony (1993) in stating that a recovery approach involves growing beyond the catastrophic effects of mental illness towards social inclusion. Shepherd, Boardman and Slade (2008) consider that recovery involves finding new meaning and purpose in one's life. For patients in a secure hospital this involves a process by which through their treatment they may gain insight, and depending on their level of treatability and their diagnoses, they may or may not be able to discover empathy and feel remorse for their past violent acts. Restorative Justice is a process by which amends are sought between victims and perpetrators. This process was exemplified in the truth and reconciliation trials in South Africa following the abolition of Apartheid.

If forensic patients are to develop feelings of empathy and remorse and an ability to relate effectively to others, they will need to experience an embodied sense of the awakening of their emotions. This might be achieved through a music therapy approach in which patients safely and gradually discover how to connect and relate to others through playing music together. This requires novel techniques to be applied in structured stages. In this challenging treatment environment a treatment manual is needed to guide and support the therapist to work safely and effectively. In the research context, such a manual has the key scientific function of ensuring treatment fidelity.

1.3 Background to the study rationale

The literature review completed in preparation for the pilot studies that were reported in Compton Dickinson, Adlam and Odell-Miller (2013), identified the current state of the evidence for music therapy with people with schizophrenia and personality disorder and the treatment approaches in forensic psychotherapy. The research base and the theoretical and therapeutic process and evaluation of cognitive analytic therapy (CAT) and music therapy were reviewed and are further considered in this thesis.

The literature review in this thesis includes more recent research findings in music therapy in forensic research, and in cognitive analytic therapy for the needs of people who have committed violent offences and who have co-morbidity of diagnosis. A separate chapter (3) then follows which covers the relevant literature and meaning of outcomes in mental health research.

1.4 Cognitive Analytic Music Therapy

Two forms of therapy in which this author is trained and accredited are integrated to form Cognitive Analytic Music Therapy. The purpose of developing this model was to create compatibility for the inclusion of music therapy into the new model of multi-disciplinary treatment pathways (National Health Service, 2008). The methodology of the main study presented within this thesis incorporates patients' and therapists' needs. Their well-being is considered as central alongside that of the organisation and the multi-disciplinary teams. The findings of systematic reviews and the National Institute for Health and Care Excellence (NICE) guidelines (CG82) for the treatment of schizophrenia (2009) and those for the treatment of antisocial personality disorder (CG77, 2012) have all been taken into account.

By formalising an ethically approved research project, the goal was to produce an evidence-based model for music therapy for the Arts Therapies Department at the research site, which is generalisable in other forensic settings. This research drew on ten years of clinical developmental work, with the objective of writing and clinically testing a forensic music therapy treatment manual through which the music therapist may feel safe and effective in working with people who have committed violent offences.

1.5 The secure hospital treatment context

Duggan, et al. (2006) emphasise the ethical importance of providing evidence-based treatments for patients who are incarcerated, who have limited choice and who are receiving treatment for serious mental disorders. This makes it all the more important to provide interventions that are acceptable to the patients and furthermore that these treatments must be seen by stakeholders to be cost-effective.

The problem for music therapists working in forensic psychiatry is primarily in how to manage risk and how to work effectively within specific overarching treatment approaches. Hervey and Odell-Miller (2013) completed a qualitative analysis of staff responses to and perceptions of psychodynamic music therapy in a unit for patients with dangerous and severe personality disorders. This highlighted the need to raise staff awareness and to offer reassurance regarding the competency of music therapists, without which responses from MDTs may be ambivalent. Without sufficient integration and information, teams struggled to understand ways in which music therapy could help patients. Lawday and Compton (2013) completed a pilot project in which, having discovered that psychodynamic music therapy was not acceptable on a ward which had an overarching dialectical behavioural approach, they developed a Group Cognitive Analytic Music Therapy (G-CAMT) model in line with Medical Research Council (MRC) guidance for developing a complex intervention (Campbell et.al, 2007)

The security procedures and induction processes for a high secure hospital are complex and lengthy. The therapeutic work in a high secure hospital can be very draining as well as fascinating and all-consuming. Patients who are admitted for long-term treatment present with potentially damaging, frequently hidden, perverse thinking and toxic behaviours which underlie the offence-related reasons for their admission. This dynamic led this author to consider the impact of work stresses on the whole of the arts therapies team: the tendency to burn out, and the challenges that all new members of the team faced when developing services in this hospital treatment setting. These included preconceptions about what would work, which were based on prior clinical experiences that were generally not compatible with, or comparable to, the extremes of working within a closed environment with the most violent of offender patients who have no access to the community.

There is great diversity in the diagnoses and needs of people who are sent to high secure hospitals. The national high secure hospitals are managed within the United Kingdom National

Health Service for treatment of people who have mental disorders and who are admitted through the criminal justice system having committed serious offences. Their mental health needs are psychiatrically assessed and their treatment is delivered by MDTs over an indefinite period of time until the patient is considered sufficiently recovered and rehabilitated to move to conditions of lesser security. In contrast, the prison population serves a fixed term as punishment as distinct from treatment. With regard to treatment, their profile of need differs significantly from that of patients in secure hospital services (Thomas, 2005).

The average length of stay for a patient in high secure treatment is six years. Separate treatment programmes, which are gender specific, are developed in secure treatment settings. At the high secure hospital where the present study was implemented, these include separate services for men with mental illness, for men with learning difficulties and for men with personality disorders. There is also a high secure facility for women who have committed serious offences. The overall treatment programme in each of these directorates involves staged treatment phases which Seiser and Wastel (2002) conclude can promote an integration of techniques that must work in harmony with each other to advance each individual patient's goals. Clinical leads in collaboration with management devise specific treatment pathways using the best evidence available for each of the patient groups. Whenever possible, the treatment programmes follow NICE guidelines (NICE 2009). The MDT assess and treat each individual patient following the set pathway of the directorate in which the patient resides, whilst also considering specific individual needs. The process aims to contribute to a measured journey through the hospital system, in terms of the rehabilitation of a person who has committed a violent offence and the treatment of his or her severe personality disorder and/or severe enduring mental illness

The challenge that the present study addresses is how to develop a time-limited form of music therapy which can be integrated into these structured treatment pathways. An acceptable model must be clinically effective, safe and user-friendly to both patients and clinicians.

Chapter 2 Literature Review

The literature, which will be discussed in this chapter, is that which underpins the present study and which was available up until the implementation of the study in 2011. Other relevant literature, which has been published since that date, will be discussed in Chapter 11 when considering the results of the study and future implications. The present study is discussed within the context of the forensic psychotherapy and its relevance to music therapy in forensic settings. The research base in music therapy, cognitive analytic therapy and the theories of group analysis that underpin the development of the G-CAMT model are also discussed. Finally, the research base, which defines patient needs, will be discussed. The literature review is divided up into sections as follows:

- 2.1 Introductory summary: the treatment context*
- 2.2 Introduction to forensic psychotherapy*
- 2.3 Music therapy background*
- 2.4 Music therapy research*
- 2.5 Systematic reviews up to 2011*
- 2.6 Cognitive analytic therapy (CAT)*
- 2.7 Rationale for a context-specific model: G-CAMT*
- 2.8 CAT theoretical underpinning of G-CAMT*
- 2.9 Forensic patients and co-morbidity*
- 2.10 Forensic music therapy research methods and tools*
- 2.11 Standard care and patients' needs*

Search engines used include Anglia Ruskin University Library, Aalborg University Library and website, the Cochrane Library, University of the West of England (UWE) Research Repository, Google Scholar, the World Federation of Music Therapy (WFMT), Music Therapy World, PubMed, Wiley online library; websites include the British Association of Music Therapy, the Nordoff Robbins Library and research base, the Association of Cognitive Analytic Therapy, the International Association of Forensic Psychotherapy, King's College London, the Institute of Psychiatry, Taylor & Francis online.

2.1 Introductory summary: the treatment context

‘Do you understand, sir, do you understand what it means when you have absolutely nowhere to turn?’ Marmeladov’s question came suddenly into his mind ‘for every man must have somewhere to turn...’ (Dostoyevsky, 1886 p.56)

Patients in secure hospitals have been removed from society through the criminal justice system for treatment because they have committed violent offences that are deemed to pose a risk to the general public. They have complex diagnoses of mental illnesses and personality disorder, sometimes both. Prior to admission, they have been psychiatrically assessed as ‘treatable’ rather than being sent to prison for punishment.

Patients receiving treatment in secure hospitals frequently have complex psychopathology, severe mental disorder and particular treatment needs during rehabilitation. Their needs towards recovery are not served by one single therapeutic intervention. In high secure hospitals psychological interventions are integrated into structured multi-disciplinary treatment pathways, which include cognitive, psychosocial, educational and occupational therapeutic treatment interventions.

In the UK this multi-disciplinary approach involves the delivery of concurrent treatments towards ensuring effectiveness of overall treatment leading to a reduction in the length of hospital stay and therefore of cost. (Glorney, et al., 2010).

Over the past decade the political drive for cost-effectiveness and clinical effectiveness has challenged researchers and clinicians because aspects of standard multi –disciplinary care must be monitored and evaluated in order to correlate these variables against the treatment effect of the intervention to be tested. Within the range of offence- related and psychological interventions available there is therefore a need to evaluate the clinical effectiveness of forensic music therapy.

In a forensic mental health MDT, a variety of professionals bring a broad range of skills, theoretical approaches and experiences to their practice. These skills are shared and reflected on in clinical ward rounds. The treatment needs of each individual patient are considered, and agreed by the patient’s MDT, who require that music therapy when delivered as a psychologically based treatment intervention, rather than as recreational or passive listening, must be soundly based within established psychological frameworks.

2.2 Introduction to forensic psychotherapy

Forensic psychotherapists are a group of professionals, trainees, volunteers and experts by experience who have an interest in the psychodynamic understanding of offending and its treatment. Members of the International Association of Forensic Psychotherapists (IAFP) come from the United Kingdom, Germany, the United States of America, Austria, the Netherlands, New Zealand, Italy and Sweden (IAFP website, 2014). The formation of the IAFP by Dr Estela Weldon to promote the psychoanalytically orientated therapies in the treatment of people who have committed violent offences was based upon the true roots of psychoanalytic psychotherapy with offenders, which started at the Portman Clinic in London with its foundation more than 70 years ago.

The aims and objectives of the association are to host an international conference every year in a different country; to promote understanding, training, research and supervision for staff across the therapeutic and medical professions who are working with people who have offended and who are detained in secure hospitals. The IAFP interacts with the criminal justice system, through which it is called upon to provide expert evidence and advice. It hosts debates, seminars and conferences that cover social and political issues, the arts therapies in forensic settings, and attitudes to offenders and their victims.

Kahr (2001) describes how it is only in the past hundred years, since the advent of psychoanalysis that the western world has started to respond more humanely to acts of dangerousness and destruction. He highlights how until then, through unconscious identification with the aggressor, prisoners were subjected to cruelty and punishment, which ranged from beatings and the stockades to lynching, torture and beheadings.

He refers to Freud (1910), who first wrote about criminal offenders' psychopathology as originating in fantasies within the mind, which are linked to the Oedipus complex. He maintained that feelings of guilt may precede a crime and then the desire for punishment relieves the feelings of guilt. Furthermore, Kahr (ibid) cites Moellenhoff (1966), who referred to Hanns Sachs, one of the first members of Freud's secret committee, who considered the death penalty to be a form of group sadism.

McGauley and Bartlett, (2009) highlight that despite the fact that psychological explanation for mental disorder was recognised early in the 20th century, forensic psychotherapy is relatively new in the treatment of mentally disordered offenders. Over the last 30 years the range of

treatments for mentally disorders offenders has developed (McGauley, 2010). McGuire (2000) considered what constituted effective psychological treatment for people who have committed offences – he noted that there were research weaknesses because people with mental disorders were often excluded from research on effective treatment for offenders as they were considered too treatment resistant. McGauley (2010, p.131) explains that this may have been the case because mentally disordered offenders are in her view ‘an atypical group’, because they are often deemed to be too ill or too disturbed to benefit from psychotherapy.

There are different areas of treatment discrimination against mentally disordered offenders (MDOs) who are receiving hospital treatment, compared with the treatment of prisoners in correctional settings. The latter have limited or fixed-term sentences, whereas the former are detained until they are deemed to be sufficiently recovered and safe to move to conditions of lesser security. The challenge, which researchers in both these areas of forensic mental health science are addressing, is to address the treatability of patients and to prove the efficacy and clinical effectiveness of psychologically based interventions for specific forensic treatment contexts and specific patient groups.

Roth, Fonagy and Parry (2005) compare the UK and USA systems of health care to demonstrate accountability of healthcare professionals and cost-effectiveness. In the UK NHS system, where healthcare is provided to the general public free of charge, the emphasis is on cost-effectiveness and clinical effectiveness. Roth, et al. (ibid) explain that this drive began in the USA and was subsequently taken up in the UK in the modernisation programme, through which the National Service Framework set standards in 1999. Further to this, the National Institute of Clinical Excellence (NICE) was established to provide guidance to the NHS. NICE was subsequently renamed the National Institute for Health and Care Excellence, and this organisation continues to provide guidance on cost-effectiveness analysis (CEA) and clinical effectiveness. Byford, McCrone and Barrett (2003b) reviewed 28 economic evaluations to examine how to maximize the benefits of limited health care resources, including psychological therapies. Of the 28 studies 11 were Randomised Controlled Trials (RCTs). They concluded that the evidence base is still too sparse to inform resource allocation decisions.

Cognitive Behavioural Therapy (CBT) became a treatment of choice in forensic psychology services, in part because the evidence base could be built on observable behaviour modifications. In taking this top-down approach, cognitive distortions and irrational thinking are considered to lead to inadequate reasoning; therefore emotions and behaviour become

disordered. Behaviour can be measured as an outcome with greater reliability than the subjective nature of feelings or thoughts. The intervention therefore developed a strong evidence base (Beck, 1970; Ellis, 1962). The behavioural sciences aim to reduce dysfunctional behaviour by analysing symptoms and changing the thoughts that maintain them. McGauley (2009 p.133) highlights that for this form of treatment to be successful the patient must understand how to apply the model to himself in order to become his own cognitive therapist, therefore this approach may not be effective for patients with intellectual impairments. As a result, this intervention alone can lead to gaps in provision for people who have committed violent offences, and who have intellectual impairment (Hatton and Taylor, 2005).

This patient group often struggles to find or to comprehend words and cognitive concepts, and they are often referred for psychodynamic music or art therapy through which emotional engagement may begin without having to speak the unspeakable, as a precursor to psychotherapy treatment (Pedersen, 1999). McGauley (2009, p.129) clarifies that psychodynamic therapy considers the unconscious meaning of mental events such as feelings and symptoms and responses. She cites Freud (1910 *ibid.*) to remind the reader that the psychodynamic process is populated by memory desires, emotions and thoughts, which may often be painful and unacceptable. She explains how the defence mechanisms identified by Freud such as suppression and repression are activated. People who have offended more often than not express confusion about themselves having suffered childhood neglect, attachment disruptions, violence, and child sexual abuse (Adshead 1997.) The impact of the trauma of these past events means that memories may be disturbing and more often than not these patients identify with their own pain in this victim state, prior to gaining understanding of their impact on others. (Cormac and Hughes 2013) The subsequent risk that may emerge according to McGauley (*ibid*) is the psychological defence of repetition compulsion, more commonly known as acting out.

The process of the above enactments is relevant to the present study because in music therapy the thoughts and ways of relating are played out both musically and verbally in the therapeutic setting. These are made visible and felt by the music therapist through the responses of the patients in their physical actions, behaviours, sounds and within the creative imagination and metaphors that arise from the musical interaction. There are multiple sensory aspects, which are specific to interactive music therapy, and additional to the verbal descriptions of psychotherapy.

This activity of both mind and body in harmony through a process of emotional affect regulation supports the integration of psychological and biological models of human development, which are described by neuro-scientific research. Schore (2003) has taken attachment theory beyond the behavioural and cognitive processes into affect regulation theory which looks at the impact of body-based affective processes during the process of maturation from infancy. It also looks at how brain maturation is affected by stress and non-conscious relational transactions.

More recent research is showing how these processes may either impair development or provide the catalyst for an ability of self-reflection to develop. This may then lead to gradual and authentic changes in interpersonal relating which amount to new, more prosocial ways of responding, reacting and behaving with other people.

2.3 Music therapy background

Definitions:

‘Music therapy is the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seek to optimize their quality of life and improve their physical, social, communicative, emotional, intellectual and spiritual health and wellbeing. Research, practice, education, and clinical training in music therapy, are based on professional standards according to cultural, social, and political contexts.’ (WFMT website, 2011)

‘Music therapy is the systematic use of music, using live active and/or receptive music in addition to thinking and talking, to engage patients in a therapeutic relationship with a registered qualified music therapist who is both a highly trained musician and a therapist’ (Odell-Miller, 2014).

Music therapists who work in the UK have completed postgraduate studies and qualification. In order for music therapists to practise in the NHS, registration is mandatory with the Health and Care Professions Council (HCPC). At the time when the present study was implemented, from 2011 to 2012, no substantial forensic music therapy outcome research had been published in the United Kingdom, and none had been undertaken in the three national high secure hospitals with people who have committed offences, who are resident in secure hospitals and who have complex diagnoses of schizophrenia and co-morbid personality disorders.

Internationally, there are many models of music therapy utilised in many different clinical fields. For the purposes of this thesis research literature discussed is restricted to the psychiatric and forensic population. In the USA, Willem Van de Wall (1924) pioneered music therapy in State funded institutions and he wrote the first text on how to implement music therapy in prisons and mental hospitals, with an emphasis on the use of singing.

There are no comparable treatment facilities in the USA to the high secure hospitals in the UK because of the death penalty. Instead, there is a correctional system, which consists of maximum-security prisons that have different issues because many of the longer -term inmates are not in treatment for rehabilitation, they are frequently secluded and many are awaiting execution on death row. Mears and Watson (2006) conducted an assessment of the American supermax prisons. Their findings suggest these institutions may cause many negative effects, preclude investment in other potentially effective strategies, and raise substantial constitutional and humanitarian questions.

Historically, in the UK, there are two distinct schools of music therapy practice, both of which have relevance to the development of the integrative model of the present study in this thesis. Paul Nordoff and Clive Robbins (1992) were pioneers of music therapy with children with autism. Central to their approach is all that occurs within the musical interaction. This began as a developmental model focused on the non-verbal aspects of child development. The model has since been underpinned by the theories of Stern (1985) and Trevarthen (2007; 2011). The development of relating in childhood as understood by these authors, and the relational patterns that develop at that time are relevant also to the theory and practice of cognitive analytic therapy (Ryle and Kerr, 2002). The integration of these concepts in cognitive analytic music therapy will be discussed later in the thesis.

Juliette Alvin (Alvin, 1966) was a pioneer of music therapy in mental health. She recognised that to promote mental health there must be a balance between body, mind and emotions in a way that links to the social, emotional and intellectual needs of the individual. She expressed her belief that music could link to the emotional and mental maturation process and therefore could influence behaviour. Her pupil Mary Priestley (1994) further developed the theoretical underpinning of music therapy with psychoanalytic theory applied to practice. She explored musical therapeutic techniques to explore the conscious and the unconscious mind; in the case of the latter, guided imagery (Bruscia, 2002) has further enhanced the field. Priestley defined

the understanding of the counter-transference and transference processes within musical interaction, as well as suggesting techniques for ego strengthening.

In exploring music therapy in psychiatry, De Backer (1999) considers whether or not to make verbal interpretations, and the primary need of a child who has suffered early attachment disturbance to be that of holding, rather than of making the unknown perceptible and understandable through words; thus he challenges the value of the purely psychoanalytic model in music therapy in psychiatry.

Pedersen (1999) describes her work with patients with schizophrenia, promoting the holding capacity of music therapy through which communication and meaningful relationship is developed at a basic level. She considers how music can touch the patient in a way that is intimate yet non-threatening. She demonstrates the clinical effect by giving examples from a single case study in which development has been affected by trauma, and 'not being related' to others created a build-up of negative experiences, which can be experienced as intrusive to the child. She explains her model as suitable for those who are considered not suitable for psychotherapy and as a first treatment.

Central to this approach in music therapy is improvised music, the purpose of which is to help the individual to access and express his emotions without necessarily having to talk about those feelings until he is ready to do so. Pedersen (1999) describes the function of the music as a medium that can metaphorically touch the patient without physical contact, and that the non-verbal context makes it possible to express and even act out even the tiniest of feelings and sensations. This is an interesting definition because in forensic treatment there are risks of violence in 'acting out'. In this thesis, consideration will be given to the context of music therapy delivery, and the structure of the model will be explored.

Pre-recorded music may have a different effect from jointly created musical improvisation, which takes place within the therapeutic relationship between the music therapist and the patient. The ways in which music is improvised has the capacity to build or break a therapeutic alliance. Odell-Miller (1999) states her hypothesis that music within the music therapy process has something specific to offer to those who find verbal communication difficult as well as to those who are very articulate but yet cannot connect their feelings to their words. Later this was expanded (Odell-Miller 2001) to consider the relationship between psychoanalysis and music therapy.

The spontaneous expression and connection between mind and body of inner feelings and states can occur within this sort of jointly created musical activity. This carries further relevance in understanding the self in relation to the other in multi-disciplinary forensic treatment, because offences involve sadistic violations of the body of another and/or masochistic self-harm (Welldon, 2002).

2.4 Music therapy research

There is little rigorous outcome research on music therapy in forensic settings.

No music therapy outcome research has as yet been published in forensic hospitals with offenders with complex and multiple diagnoses of schizophrenia and co-morbid personality disorder.

Two community-based RCTs have been carried out with patients who have diagnoses of schizophrenia and other psychotic disorders. Talwar, et al. (2006) conducted a feasibility RCT in which they explored whether music therapy may provide a means of improving mental health among in-patients with schizophrenia. The conclusions of this study state that an RCT for music therapy for in-patients with schizophrenia is feasible. The authors state that their findings indicate symptom reduction and justify a further explanatory study of how music therapy may help people who suffer with schizophrenia. Gold, et al. (2005) state that music therapy is usually not tailored to a specific diagnosis and that factors unrelated to psychiatric diagnosis, specifically therapy motivation, should be considered when specifying, prescribing and evaluating psychotherapies. This trial further demonstrated that for in-patients with schizophrenia, music therapy might improve motivation.

Duggan, et al. (2006) state that the needs and issues of stakeholders and clinicians within secure hospital settings require consideration with regard to feasibility and acceptability of conducting research with people who have limited choice and no access to the wider community.

At the time of implementation there was a developing amount of literature on music therapy in forensic settings. The principal investigator had written and published several papers describing the clinical development of cognitive analytic music therapy (Compton Dickinson, 2003a; 2004; 2006). Soft evidence in the form of a series of single cases of cognitive analytic music therapy (CAMT) with before and after evaluations at a national high secure hospital is cited in the NICE antisocial personality disorder (ASPD) scoping document (2007). Patients with diagnoses of

personality disorder or co-morbid diagnoses with mental illness who received 24 sessions of CAMT with 3x once monthly follow-up sessions showed a reduction of psychopathology to a normal level whilst remaining in the high secure hospital environment, as measured on the Persons Relating to Others Questionnaire (Birtchnell and Evans, 2003) (Appendix 3a). One female patient was transferred to medium secure treatment as a result. All patients demonstrated changes in the eight domains of relational abilities, all were deemed ready subsequent to this individual treatment to engage in group therapy. As a result of this developing stage of evidence, NICE responded that art and music therapy would be included in the guidelines. Other studies consist mainly of small qualitative case study samples with a psychodynamic and psychoanalytic theory base (Sloboda, 1999; Santos, 2001, unpublished; Glyn, 2002; Glyn, 2009). At this point there had not been any music therapy RCTs or single case series carried out with personality disordered offenders.

2.5 Systematic reviews up to 2011

Gold, Voracek and Wigram (2004) conducted a meta-analysis of all music therapy studies that focused on children and adolescents with psychopathology. Their view is relevant because it suggests the need for studies on the efficacy of models of music therapy that are currently practised in Europe, and on the clinical effectiveness of models of music therapy in specific clinical settings. They compared music therapy with no treatment or with a different treatment. Those studies that compared before and after music therapy treatment were also considered as possibly relevant. Eligible designs in this review included treatment versus control group, pre-test post-test designs, and treatment group only pre-test post-test designs. A systematic literature search, both computerised and manual, was undertaken. The conclusions state that the clinical implication of music therapy is an effective intervention for children and adolescents with psychopathology.

The above meta-analysis concluded that music therapy produces a clinically relevant effect of a considerable size and is therefore recommended for clinical use. Specifically, clients with behavioural or developmental disorders or with multiple psychopathologies may benefit from music therapy.

Gold et al. (ibid) further suggest that if these findings can be replicated for varying models and settings, this will strengthen their clinical applicability. Results revealed that after exclusion of an extreme positive outlying value, music therapy has a medium to large positive effect

(ES=.61) on clinically relevant outcomes that were statistically highly significant ($p < .001$) and statistically homogeneous. No evidence of a publication bias was identified. Effects tended to be greater for behavioural and developmental disorders than for emotional disorders; greater for eclectic, psychodynamic, and humanistic approaches than for behavioural models; and greater for behavioural and developmental outcomes than for social skills and self-concept.

Maratos, et al. (2008) conducted a systematic review for the Cochrane database of all RCTs which compared music therapy and standard care with standard care alone for the treatment of depression. Five studies met these criteria. However, the authors' conclusions note the poor methodological quality of these studies, and that owing to the variations in interventions and populations a meta-analysis was not possible. Furthermore, the authors concluded that it was not possible to have confidence in the effectiveness of music therapy in depression compared with standard care alone or with other psychological and pharmacological therapies. The summary, however, delineated the difference between active music therapy techniques in which improvisation is used, and receptive music therapy in which pre-composed music is used for relaxation, reflection and change of mood states. The recommendation of the systematic review is that long-term effects of music therapy require further research. Therefore, the follow-up measurements and the observational ratings in the present study should make a positive contribution to the corpus of knowledge.

Gold, et al. (2009) completed a systematic review of music therapy for people with serious mental disorders. All existing prospective studies were combined using mixed effects meta analysis models. The influence of study design, mental disorder and dose effect were taken into account. These authors considered that music therapy might be effective with treatment resistant patients; they concluded that when music therapy is added to standard care, as in the present study, it has strong effects on global state and general and negative symptoms. They note that there is a small effect size in 3–10 sessions and that large effect size occurs in 16–52 sessions. Although the present study was of 16 sessions of treatment, the patients are known to be treatment resistant; therefore a large effect size is not predicted.

Bittman, Dickson and Coddington (2009) considered creative musical expression as a means to improving quality of life for inner-city adolescents who had been referred through the courts to residential treatment settings. This study used a range of well-validated outcome measures including the Adolescent Anger Rating Scale (AARS) (Burney, 2001). The results after a six-week follow-up period yielded statistically significant improvements. Similar to the present

study, a difficulty was encountered in sustaining the masked status of the research assistants who were delivering the outcome measures. Improvements were found in anhedonia negative affect, namely in terms of behaviour and relating to others, total and instrumental anger as well as interpersonal problems. Quality of life was too broad a scope to cover.

A further systematic review of music therapy for people with schizophrenia and schizophrenia-like disorders was completed by Mössler, et al. (2011). They searched the Cochrane Schizophrenia Group Trials Register and contacted authors working in the field. They then hand-searched music therapy journals and reference lists. Studies where attrition was more than 30% in any one group were excluded. Treatment dosage and treatment approaches were examined. Studies took place over a period of one to four months. There were a total of eight studies in which altogether there were 483 participants. Music therapy added to standard care was found to be superior to standard care for a global state with a 'good' effect reported on improvement of negative symptoms using the Scale for the Assessment of Negative Symptoms (SANS).

Negative symptoms according to Andreasen, et al. (1995) consist of five subscales of affective flattening: alogia, avolition-apathy, anhedonia, asociality and attention.

Lyne, et al. (2013) cite McGlashan and Fenton (1992) and Milev, et al. (2005), who maintain that negative symptoms are predictors of poor outcomes.

The above findings support this author, who suggests that patients who have committed serious offences, who are in long-stay hospital treatment and who have negative symptoms of schizophrenia are a treatment resistant patient group. The above systematic review makes a recommendation that the relevance of outcome measures selected in relation to music therapy requires consideration. This aspect will be covered in Chapter 3.

This same systematic review concludes that music therapy helps to improve global state for people who suffer with schizophrenia, and that the implication is that social functioning is improved if there are sufficiently high doses.

In music therapy, the use of music (i.e. playing or listening to music) can often be the catalyst and a motivating factor for patients to forge a working alliance, whilst until then they had not been motivated or able to build a relationship. Gold (2005) suggests that low motivation for (other) therapy can become a reason for referral of a patient to music therapy, and such factors

may at times be more important than the patient's primary diagnosis. However, there is a scarcity of research addressing the effects of music therapy for patients with low therapy motivation. Therapies per se are less effective if patients are not motivated. However, Horvath (Horvath and Symonds, 1991) found a moderate but reliable association between good working alliance and positive therapy outcome. This suggests that more research is required on how patients in music therapy relate to each other; furthermore, that there is a positive implication for the actively positive therapeutic relationship which is promoted in cognitive analytic therapy (rather than an initial negative transference).

2.6 Cognitive Analytic Therapy (CAT)

Cognitive analytic therapy (CAT) (Ryle and Kerr, 2002) is an integrated yet distinct model of time-limited, relational psychotherapy which has developed in the United Kingdom NHS over the past 30 years, primarily through the work of Dr Anthony Ryle (1995a) at Guy's and St Thomas' hospitals in London. Ryle took an approach based on the whole person, and sought more clinical evidence in terms of both process and research outcomes. Casement (1985) described the reflective process from the psychoanalytic perspective, by which on learning from the patient one can better understand one's own contributions to the process of building an effective therapeutic relationship by understanding the unconscious cues from the patient. In this way, Casement demonstrates how failures to respond effectively to the patient may be remedied.

Akande (2007) noted that the CAT concept of the 'observing eye' by which one may more objectively see oneself can be a disturbing experience for the patient, making it all the more relevant that the CAT therapist themselves firstly has this self-awareness as the more experienced other.

Key concepts of CAT process are taken from Vygotsky's (1978) Activity theory in which learning from the more experienced other, through experience and attunement within non-didactic 'scaffolded' learning, involves a collaborative relationship.

In CAT, diagrams are made which identify the individual's particular relating procedures. The purpose is to recognise outmoded relational procedures which develop in childhood, but which no longer achieve the desired response. In this way, more effective strategies can be explored. During the assessment period a realistic target problem for a short piece of therapy is formulated.

The development of the Multiple Self-States Model (MSSM) (Ryle, 1997a) (1997b) is used specifically in CAT for the treatment of personality disorder. Through visual mapping and recognition of previously disavowed states of being, as observed and experienced by the therapist, the patient can be helped to understand why he often does not feel all of one piece, and why he suffers feelings of distress and discontinuity. The MSSM is useful to identify rapidly shifting self-states and moods, which can be fleeting with sudden changes or all-pervading (Potter, 2004).

CAT has an increasing evidence base, since therapeutic process can be monitored through the development and implementation of practice-based evaluation and measurement tools. These include the psychotherapy file (Wilde McCormick, 2002), the therapy response record, the helpful aspects of therapy (HAT) and the States Description Procedure.

A primary client group are the cluster B group of personality disorders (American Psychiatric Association, 2000). This group includes the antisocial, borderline, histrionic and narcissistic subgroups. These conditions are present as concurrent diagnoses in the population of the present study.

Chanen, et al. (2008) conducted a randomised controlled trial of N=86 to compare up to 24 sessions of CAT with manualised Good Clinical Care (GCC) for outpatients with Borderline Personality Disorder (BPD) who were between the ages of 15 and 18 years. Whilst there was no statistically significant difference between the two groups at 24 months' (two years') follow-up, the CAT patients showed signs of having improved more rapidly, with reduced externalising psychopathology. This is interesting because CAT is not a manualised therapy; however, G-CAMT and GCC are both manualised.

Chanen, et al. (2009b) conducted a further RCT to compare a team-based intervention for Helping Young People Early (HYPE) with BPD with historical Treatment as Usual (TAU) in a quasi-experimental design with a sample size of N=32. Outpatients receiving TAU were compared with those in the team-based intervention (which consisted of time-limited CAT, case management and psychiatric care) who were the participants in the previous Chanen, et al. (2008) RCT of sample size N=78. The results showed greatest median improvement in the four outcome measurements for CAT with the HYPE model. The implication here is of a multi-disciplinary approach giving the best results with CAT and that in statistical analysis, median

measurements are appropriate in research in CAT because of the diversities within this patient group, thereby controlling for outliers.

Kellett (2005) developed a single case experimental design (SCED) in which frequent sampling during treatment identifies the links between specific input and sudden therapeutic changes. Kellett utilises these process measurements to establish qualitative links between significant positive therapeutic changes and the use of CAT therapeutic tools. His methodology involves an A/B design, and he assessed seven dissociative variables at baseline: period A, and then in treatment period B. Treatment was delivered over 24 sessions. In this way, Kellett evaluated the impact of specific CAT tools as active therapeutic components within the therapeutic process, which led to sudden gains. This ingenious design enables statistical measurement of therapeutic process during which dissociative traits were seen to diminish.

This evidence of the effectiveness of CAT is supportive to the present study as an indicator that dissociative traits may be reduced. This will be measured in the present study on the multiscale dissociation inventory (MDI) (Briere, 2002).

Bennett and Parry (1998) report on the effectiveness of using a self-states sequential diagram (SSSD) (Ryle and Beard, 1993) as part of the reformulation process in CAT to promote accuracy. The SSSD was validated against the Core Conflictual Relationship Theme Method (CCRT) (Luborsky and Crits-Christoph, 1990) as well as against the Structural Analysis of Social Behaviour-Cyclic Maladaptive Pattern (SASB-CMP) (Benjamin, 1974; 1987; Benjamin, et al., 1986; Schacht and Henry, 1994).

This is important because in the present study the music therapists were guided in how to make these diagrams in weekly CAT supervision, which was provided by the principal investigator. They are unique in music therapy practice to the G-CAMT model, the purpose of which was towards promoting cognitive understanding of relational patterns.

In Bennett, Parry and Ryle's (2005) audit of current practice and study of the process of change in CAT with BDP, numerous measures are proposed. These include useful researcher measures of therapist competence. These are used to evaluate consistency so that both the treatment effect and the therapeutic relationship can be more accurately defined and evaluated. In the event, in this study they were not used, as this would have added

additional stress to the music therapists, both of whom were already experienced postgraduate qualified registered therapists.

Bennett and Parry (2004) have developed 'A measure of psychotherapeutic competence derived from cognitive analytic therapy'. This has ten domains of therapeutic competency. These are taken from psychotherapy standards developed by the United Kingdom Council for Psychotherapy (UKCP). Audiotaped sessions are monitored and rated.

Bennett, Pollock and Ryle (2005) further suggest specific measures that could be completed by patients. These include the Personality Structure Questionnaire (Pollock, et al., 2001), the Dissociative Experiences Scale (DES) (Putnam and Bernstein-Carlson 2004), and the Therapy Response Record (TRR) and Personal Questionnaire (Ryle and Golyunkina, 2000).

Ryle and Golyunkina have also developed a 'borderline index of severity' tool in which the nine borderline features of DSM-IV can be rated for severity on a nine-point scale. These range from mild or absent to symptoms that destroy relationships and the ability to work or which are a threat to life. This tool could have further defined the differences of severity within participating research subjects.

Bennett, Parry and Ryle (2006) address the problem of drop out by exploring whether and how therapists can recognise and resolve threats to the therapeutic alliance. These may occur through enactments within the patient's old relational patterns. The authors used a task analysis method (Greenberg, 1984a) in which independent raters identify threats to the therapeutic alliance within transcribed process notes. By looking at cases that had good outcomes compared with those that had bad ones, it could be recognised that in the poor-outcome cases the therapist failed to notice the enactments.

In the present study, the music therapists had weekly supervision in the CAT model in which they were supported in recognising in themselves any potential relational threats to the working alliance, and then, having learnt from the supervisor how to do a diagram, they repeated the process with their trial treatment groups.

In cognitive analytic therapy (Ryle and Kerr, 2002), the concepts of transference and counter-transference are actively used. Ryle (1995a; 1995b; 1997a) reconceptualised these relational phenomena, in order to facilitate patient understanding of the therapeutic relational experience

within the constraints of a time-limited therapy framework. Developing original psychoanalytic theory and practice, Ryle refers to the cognitively orientated reconceptualisation of transference and counter-transference as reciprocal-role relating. For example, a patient who presents with a negative transference may be perceived as rejecting and hostile, yet this may be ameliorated when he understands that he has unconsciously re-enacted an internalised early negative experience of feeling rejected. This can be recognised as a repeated pattern through diagrammatic work within the sessions. Once the patient can see that he has internalised both the rejecting and rejected experiences, and that he may therefore enact either polarity of that reciprocal role (or of any other experienced relating role, whether it is positive or negative), he can consider with the therapist how to ameliorate the extremes of response, which may be unhelpful. To begin with, a therapeutic tool called the psychotherapy file (Lapworth, Sills and Fish 2009) is used to identify faulty relating patterns that have built up over the years.

Ryle (1997b) explains how the therapist, by working with counter- transference, provides an example of being able to feel and to reflect on feeling through which the emotional vocabulary of the patient may be extended. He furthermore explains how transference communications can be both direct through behaviours, and indirect through difficult feelings and experiences. When the therapist is open to receiving these, they can be mapped out as visual representations of reciprocal role procedures (RRPs). By making the process explicit verbally, it may be cognitively understood at a level that precedes a deeper level of insight and self-awareness.

Central to CAT practice is the sense of collaboration and jointly created activity which is drawn from Vygotsky's (1978) social concepts of non-didactic learning whereby what the child or patient does today with a more experienced other, he will do on his own tomorrow. This is known as the zone of proximal development (ZPD).

Through relational attachment and by recognising what he can do; what he can do with help (the area of the ZPD); and what he cannot do but may aspire to do, the child or patient may further develop his cognition through social learning. The above concepts have been further applied within the exploration required in jointly created improvised music (Compton Dickinson, 2006).

2.7 Rationale for a context-specific model: G-CAMT

Developing and evaluating a complex intervention requires theoretical and practical understanding of how the intervention causes change (Craig, 2008). A complex intervention is

defined as being made up of various interconnecting parts. The Medical Research Council (MRC) framework for the design of complex interventions (Campbell, Fitzpatrick and Haines, 2000) recommends a phased approach to the evaluation of these complex procedures. In this way, a hierarchy of quantitative and qualitative evidence is built up. The revised MRC guidance (Craig, 2008) recognises that this process may not follow a linear progression, and that there are specific difficulties in defining, developing, documenting and reproducing complex interventions that are subject to more variation than a drug.

Campbell, Murray and Darbyshire (2007) further describe the tasks involved in the modelling and piloting stages of developing a complex intervention. G-CAMT is designed to follow these structured stages in order to identify the active ingredients within this complex, integrated intervention as well as the qualities of the independent variable: jointly created musical improvisation. The purpose of this structured, staged approach is specifically to consider how to safely and creatively promote and measure positive changes which occur in music therapy for vulnerable patients who have committed violent offences.

Margison, et al. (2000) suggest that manualised therapies have better outcomes. The challenge, therefore, was to consider how a specific music therapy approach could be developed to fit with established cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT), overarching treatment models and psychological offence-related treatments. This aspect will be explored in greater detail in the pilot section of Chapter 4 of this thesis.

The group analytic concepts of Foulkes (1964), which commonly underpin music therapy groups (Davies and Richards, 2002), operate in a modified time-limited manner within G-CAMT. Blunden (2008) utilises the social concepts of Foulkes's model of group analytic therapy in CAT supervision training, which is conducted in a group format. She facilitates the participants' experience of the fundamentally social nature of CAT as well as recognition of the unconscious psychoanalytic processes. This empirical understanding of the compatibility of the two models, through personal and professional development during supervisory training and apprenticeship, was a necessary learning process towards this author's development of this integrated form of music therapy.

2.8 CAT theoretical underpinning of G-CAMT

Music therapy in groups involves observable phenomena between group members in the form of non-verbal behaviours and responses that occur in jointly created musical improvisation. The spontaneous nature of improvisation facilitates the expression of unconscious emotions that arise at that time in the therapy room.

In turn, this process may lead to the conscious recognition of those feelings, which were previously dissociated.

Modifications of Foulkes's principles in the G-CAMT model were necessary due to the pre-agreed time-limited structure of G-CAMT. This inevitably imposed restrictions on the duration and process of group analysis but was necessary both for a time-limited research project and for service delivery in forensic settings. Therefore, additional CAT tools in the form of a 'goodbye letter' were incorporated by which the music therapists and patients could move towards closure of the course of treatment. Music therapists are not trained in CAT specifically, so the G-CAMT treatment manual was developed as a guide specifically designed towards mitigating risks of harm to staff and patients in forensic treatment settings as well as ensuring treatment adherence during the research project.

The jointly created musical component, which is non-verbal and emotionally related, is the active ingredient that has demonstrated across diagnoses the function of creating a bridge between dissociated self-states (Compton Dickinson, 2006). The clinical presentation described in this case led this author to reflect on the fact that it is the sudden shift between different self-states that increases the risk of violence and of unpredictable behaviour, and which may be mediated more smoothly through jointly created attuned musical improvisation. Potter (2004) states that self-states 'can saturate, or haunt, or empower our sense of self and other. They can be dreadfully avoided as can the people or persons, or memories of place and time that are associated with them. We can get stuck in them, be triggered by events into or out of them. We can set our freedom of will and consciousness against them and ride over them. We can lose ourselves in them.'

Fachner (Aldridge and Fachner, 2006) considers altered states of consciousness through the use of music. These may be akin to self-states, but they can be explored with personal intention, for example in the process of shamanic journeying or drug use, thereby inducing voluntary physiological changes. These changes of state can affect the rhythm and nature of alpha, beta

and theta brain functions, and can create altered experiences of consciousness, i.e. evoked states of consciousness through the use of drugs. Alternatively, states may be changed because of pathology or traumatic events, such as in post-traumatic stress disorder. In the latter situation the individual is at the mercy of his instinctual drives rather than in control of his experiences. Tinnin (1990) links this phenomenon to the deactivation of neural pathways across the corpus callosum. He hypothesised that early trauma leads to dissociated, disavowed part-‘self-states’ through dysfunction of the corpus callosum. The result of this is the formation of split-off disavowed self-states as in dissociative identity disorder (DID). Kellett’s (2005) single case experimental design (SCED) described earlier in this chapter is used in CAT treatment of DIDS to measure sudden gains.

Bearing in mind the highly disrupted relational patterns which are common to the patient group in the present study, the role of jointly created music in G-CAMT is designed to gently mediate any potentially emotionally traumatic effect whilst promoting reactivation of the links between non-verbal and verbal aspects of communication, thus creating links between the left and right hemispheres of the brain via the corpus callosum. The effect is to promote a sense of the individual being more ‘all of one piece’ through the re-avowing of dissociated self-states through memory recall.

CAT is currently used in forensic treatment settings as an overarching MDT model in women’s services and in the treatment of men with severe personality disorders. The structured form of G-CAMT using CAT tools is designed to reduce risk of violence by gradually helping patients to safely develop their mindfulness and self-reflective abilities without raised anxiety. Through the increased ability to recognise emotional states whilst making music, recognition of the accompanying thoughts and dysfunctional behaviours which require revision can develop. The group-work process is designed to improve distress tolerance of difficult emotions, and to develop interpersonal effectiveness by extending the repertoire of relating procedures towards others in the group.

2.9 Forensic patients and co-morbidity

Patients who suffer with severe enduring mental illness, namely schizophrenia, and who have committed offences usually have complex diagnoses of co-morbid personality disorders, which include borderline, narcissistic, anxious avoidant, paranoid and/or antisocial personality disorder traits.

The presence of personality disorder as co-morbid is a challenge to treatability. Cleckley (1941) first noted what he called ‘the mask of sanity’ and charm with which patients with psychopathic and sociopathic personality disorder can present, and how this conceals behind it a fundamental lack of emotional engagement. Roth and Fonagy (2005) point out that co-morbidity impacts most on long-term patients in specialist settings and that whilst they may recover from the primary Axis 1 disorder, the co-morbid condition may remain. Main (1957) made a retrospective study of patients whose treatment had been considered to be a failure. He discovered that the reason for this was their ability to make a special relationship with a staff member which became unhealthy by repeating a perverse relating pattern. This remains a risk that perpetuates for all clinicians who engage in therapeutic treatment, particularly in music therapy, because the therapist is actively engaged in the creative process, which can feel intimate and risky in nature (Compton Dickinson, 2003a).

Personality disorders are psychiatric conditions relating to functional impairment, and to psychological distress resulting from inflexible and maladaptive personality traits. At the time this study was implemented there was no universally accepted definition of severe personality disorder. The National Collaborating Centre for Mental Health for the NICE Guidance on Treatment and Management of Borderline Personality (1999) disorder suggested that severe personality disorder should be characterised by ‘gross societal disturbance’ along with ‘gross severity of personality disorder within the flamboyant group and a personality disorder in at least one other cluster’.

McMurran (2006) states that the diagnoses of personality disorder suffer problems of validity and reliability. Such diagnoses can be unreliable, and the implications of co-morbidity are such that McMurran emphasises that clinicians should always assess for personality disorder. She highlights that treatments should take into account multiple diagnoses. There are research implications because ‘pure’ cases of any personality disorder are a rarity. McMurran recommends that research in high secure hospitals involves three important elements: systematic reviews; development in theoretical understanding of personality disorder and psychopathy; and evaluation of theoretically based treatments.

Campbell, et al. (2008) in the MRC guidance for developing a complex intervention grade the levels of evidence across five stages, from pre-clinical to modelling, leading at phase two to an exploratory trial. This author suggests that the present study has feasibility as a clinically based research study rather than being an intervention which is based purely on theoretical

perspectives, because the methodology is that of a single-site feasibility patient preference randomised controlled trial, which falls within the phase two stage.

In the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000), personality disorder is a class of mental disorders defined as an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the culture of the individual who exhibits it. (The general criteria for personality disorder were revised in 2011 in preparation for the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) (2013).

Personality disorders are characterised by problems in interpersonal functioning, affect regulation, impulse control and perception and interpretation of self, others and events. These difficulties lead to clinically significant distress or impairment in important areas of functioning, and in some cases are associated with violent behaviour. The DSM-IV-TR describes the essential feature for a diagnosis of antisocial personality disorder as a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. Deceit and manipulation are considered essential features of the disorder. Therefore, it is essential in making the diagnosis to collect material from sources other than the individual being diagnosed.

There have been two major systematic reviews of the treatment of personality disorder in offenders: a systematic review of the effectiveness of pharmacological and psychological treatments for personality disorder (Duggan, et al., 2006; and a review that was undertaken at the high secure Broadmoor Hospital (Lee, 1999) for their clinical decision-making support unit.

The review by Duggan, et al. (2006) recognises that no research has been undertaken in the treatment of the aetiology of personality disorder, but that there has been research in symptomatic treatment of associated behavioural problems such as substance misuse and the use of pharmacology. The review concludes that for people with personality disorders problems may become better or worse as a result of 'talking therapies'. Therefore, the recipients of treatment, particularly as they are kept in conditions of social constraint in secure treatment settings, would expect practitioners to be acting on strong and positive evidence. The implications for research are that, with the exception DBT, all therapies in the review would benefit from further evaluation. Evidence of how these treatments may affect the behaviour and mental state of people with personality disorder could, according to Duggan, prove the condition to be less intractable than previously thought. The review further recommends that

more needs to be known about short-term psychodynamic therapy, brief adaptive therapy and cognitive behavioural therapy.

The NICE guidelines for the treatment of ASPD were published in January 2010. This document provides a methodology checklist for conducting RCTs, stating that the only difference between treatment and control groups should be the treatment under investigation. Flow charts are provided as a framework for risk assessment and management.

The present study follows this guidance; however, as will be discussed later, the content of standard care across the two treatment arms: namely the control group who received standard care, and the treatment group who received standard care plus G-CAMT, contained diverse elements linked to individual needs, thereby creating additional variables.

The review by Lee (1999) addresses the treatability of personality disorder, and the debate about aetiology of the syndrome and the incompatibility of legal and clinical systems. Lee concludes that there is an urgent need for treatment outcome research but acknowledges that this patient group presents clinicians with an unusual number of treatment difficulties, largely because patients are reported to lie about their behaviour and minimise its seriousness. This author notes that such perverse behaviours create a problem for the reliability of self-report evaluations because the results of outcome measures and evaluations can vary depending on which self-state (e.g. victim state or perpetrator state) the patient is in at the time (Ryle, 1997a, 1997b).

Lee's findings concur with McMurran's (2006) recommendations that the assessment process is vital in order for clinicians to formulate an appropriate treatment plan.

Most relevant are Lee's findings that with this patient group traditional methods of treatment based on one form of therapy only, and over a long period, are not effective in the treatment of psychopathy. Instead, multiple treatments are required concurrently. Finally, Lee highlights the importance of recognising the pre-dispositional signs in childhood, such as attention deficit and conduct disorders, which could have been treated in childhood and adolescence before they had the chance to develop into more ingrained personality problems. The implication of the lack of early intervention is the development of avoidant and insecure attachment relational patterns.

2.10 Forensic music therapy research method and tools

The problem of high dropout rates encountered in the community music therapy study conducted by Talwar, et al. (2006) was addressed in two ways in the present study. Harty and

Shaw (2004) acknowledge that treatment compliancy is higher in secure treatment settings where patients are confined under mental health section following admittance through the criminal justice system. Their report identifies that unmet needs for the secure hospital total population were most frequently reported with daytime activities, substance misuse, sexual offending, safety to others and psychotic symptoms. The report states that most clinical and social needs were met. This suggests that members of this patient group are frequently well motivated to attend and compliant to treatment with the aim of moving towards conditions of lesser security. However, there are long-term patients who have low motivation. This latter group are often regarded as treatment resistant. The trial conducted by Gold, et al. (2005) indicated that music therapy could improve motivation. The secure hospital population has a more limited sense of choice about whether or not to attend than community-based patients. Whilst the Talwar study (ibid) may have been impaired because patients with schizophrenia struggle with anxieties about travelling to treatment venues, this is not a factor within the confines of a secure hospital. The issue of choice about whether and how to participate was addressed by revising the methodology to that of a patient preference trial (Torgerson and Sibbald, 1998) after the second pilot project.

Stirman, et al. (2005), Morrison, Bradley and Westen (2003) and Slade and Priebe (2001) argue that in proposing an RCT in psychotherapy the problem remains of how to yield sufficiently reliable or valid findings due to variations in Treatment as Usual (TAU) factors, co-morbidity, severity and multiple personality traits. Bateman and Fonagy (2001) addressed these factors in a follow-up study comparing the treatment of BPD through psychoanalytically orientated partial hospitalisation with that through standard psychiatric care. They monitored other treatments received throughout the study. Those receiving the psychoanalytically orientated therapy sustained improvement at follow-up in the community at 18 months, and improvement in social and interpersonal functioning in the treatment group suggested that deeper levels of change were stimulated through this intervention. However, the groups were not matched, so non-parametric tests were used, namely the Mann Whitney to test the differences between groups, and the Friedman's within groups to test for remission or relapse across time. These tests were similarly applied in the present study in which standard care was similarly monitored.

Odell-Miller, Hughes and Westacott (2006) conducted a mixed methods study from which the findings were used to create a Music Therapy Patient Satisfaction Questionnaire for the present

study (Compton, Beeley and Odell-Miller, unpublished). This questionnaire will be discussed in Chapter 5.

2.11 Standard care and patients' needs

The National Service Framework for Mental Health Modern Standards and Service Models (1999) brought forensic mental health into the NHS research and development programme. The new structure focused on health technology assessment (HTA).

This priority explored cost-effectiveness in promoting health and improving long-term rehabilitative care. The second priority was to produce and promote research evidence in service delivery and organisation. The third priority was to develop innovative interventions and healthcare products to enhance quality, efficiency and effectiveness. It was with these three priorities in mind that the G-CAMT initiative was developed to make a contribution to forensic mental health science and care.

The above three programmes were supported by a fourth initiative, which was to address methodological challenges in developing work of relevance in the NHS. Finally, the fifth programme of work was to ensure that service users could influence the research agenda. All the above contributed to the development of the present study and the selected methodology, which involves direct involvement of the patients in giving their views and preferences, not only in terms of their ability to choose to be in a patient preference trial, but also in terms of providing qualitative data on what they liked, disliked and what they felt worked best for them personally in helping them through their treatment pathways.

Byng, et.al (2004) conducted an exploratory cluster RCT of shared care development for long-term mental illness. 335 patients were assessed for satisfaction of the service, unmet needs and mental health; service costs and intervention costs were measured of a programme called Mental Health link (MHL). Twenty-three urban GP practices were allocated with funds to provide to their long-term mental health patients either standard service development or the MHL programme. The results reported a statistically significant difference in the relapse rate of the intervention group (MHL) compared with the control (mean=0.39 versus 0.71 respectively $P=0.02$). Practitioners involved in the intervention reported that they were more satisfied with intervention services, and as a result, these services improved significantly as compared with the control group. However, MHL cost a mean price of £63 per patient more for the improvements in practitioner and service satisfaction for patients with long-term mental illness. This author

suggests that over the longer term the additional cost may ultimately be validated if in comparison the relapse rate is greatly reduced. Improvements in service development in the above study were not documented as improvements in care because much of the feedback was through the better communication and the shared sense of team care that developed. This study, whilst it is a large, multi-centred quantitative study is relevant to the single-site present study because the two studies both explore the views of those involved. Additionally, the development of MHL and this study follow the same MRC guidance for the development of a complex intervention tailored to the treatment context.

To summarise: at the time of implementation of the present study, a range of music therapy models were used in forensic settings but the evidence base was sparse. A context specific model had not been identified or developed which took into account the risks of violence to music therapists bearing in mind the psychopathology of the patient group. In contrast, group analytic concepts had been applied to music therapy in psychiatric settings over many years (Davies and Richards 2002) however this model had not been adapted to fit within a time-limited treatment model. Cognitive analytic therapy however was relatively well established as an over-arching multi-disciplinary approach in some forensic settings in the United Kingdom

The present study will contribute to the corpus of knowledge by incorporating the preferences of the patients themselves, coming as it does from a clinical background of understanding of the context of the research setting in which the music therapists who delivered the trial were embedded within permanent clinical posts.

The following chapter will consider what are outcomes of interest and how we decided to use them.

Chapter 3 Outcome Measures

This chapter will consider firstly quantitative measurement methodologies suitable for outcome research, the purpose of which in this feasibility study was towards developing the evidence for a context specific complex intervention: firstly by defining what outcomes actually are, and then exploring how and why we measure specific outcomes in the forensic treatment setting. The outcomes of interest in forensic music therapy are then considered and the case is made for why relational changes are an outcome of interest, along with the development of empathy. 3.3.2 explores the literature and concepts which underpin how to measure empathy 3.3.3 considers the construction of the primary outcome measure that is used in this study and 3.3.4 demonstrates the similarities, differences and overall compatibility of the observational measure with the primary outcome measure.

3.1 What are outcomes and how do we measure them?

3.2 Use of outcome measures in forensic music therapy

3.2.1 Satisfaction measures

3.2.2 Standardised evaluations of music therapy

3.3 Outcomes of interest in forensic music therapy

3.3.1 Why measure relational changes?

3.3.2 How do we measure empathy and emotional relatedness?

3.3.3 The persons relating to others questionnaire

3.3.4 Observational measurements

3.1 What are outcomes and how do we measure them?

Outcome research involves exploring the strengths and limitations of an intervention with the goal of understanding the end results of particular health-care practices.

The objective is to achieve the best approximation of the truth about the relationship between the treatment and the outcomes.

Evidence-based practices in mental health services are defined by Drake, et al. (2001), as interventions for which there is scientific evidence that consistently shows improvement in patient outcomes. Good clinical practice involves the monitoring and evaluation of mental health services so that high standards can be achieved and maintained.

Slade (2002) gives five reasons why measuring outcomes in mental health is more difficult than in other areas of health care. He states that the effect of treatment in mental health services may be to maintain current levels of functioning or towards slowing the decline – for example in organic brain disease. The score on a measure may not then improve, despite the best clinical care. This aspect is equally relevant to treatment resistant patients. Slade (ibid) therefore notes that agreement is required with regard to what constitutes a positive outcome. He names three different target areas of mental health services in which the outcome data needed is different:

1. Specific interventions.
2. A programme that combines different treatment components.
3. Programmes for defined patient groups in specific areas.

The above raises the question of how to integrate and agree on the desired outcomes for the specific intervention of music therapy within a multi-disciplinary forensic treatment approach.

Thomas (2005) cites the value of the Matrix Model of Tansella and Thornicroft (1998), which looks at changes in functioning, morbidity and mortality in patients with mental disorders. Outcomes can be defined on a geographical dimension – at patient, team and national levels; and on a temporal dimension – at input, process and outcome phases.

The Tansella and Thornicroft model is relevant to the present study when considering the development of a complex, integrated model of treatment within the overall MDT treatment of a patient who has committed a serious offence. The independent variable of music therapy may lead to a change in functioning in terms of changes in the relational abilities of the individual to others. This study will explore outcomes in how relational patterns may change over the course of treatment, and whether there is sustainability of treatment effect over the longer term.

The main objective of CAT, the psychotherapeutic model within which G-CAMT sits, is to help patients to recognise and confront ways in which they have not revised certain maladaptive forms of thinking and responding. One of the research challenges in this study is therefore to consider how to measure outcomes in non-verbal as well as verbal relating alongside verbal self-report measures and observational outcome measures. Attkisson et al (1992) outline criteria by which to administer primary and secondary measures temporally (across time) are met at the input, process and follow-up points. Thus the change or lack of change, having controlled for

variables, becomes an indicator of whether the patient has improved in their relational abilities both inside and outside the therapy group. Positive change in this area is one outcome within the overall MDT approach, which indicates whether sufficient progress has been made for the individual to move to conditions of lesser security.

Over the two years since the end of the implementation stage, by collecting data of patient progress through the treatment pathways towards lower security, treatment and control subjects can be compared. If this study indicates a quicker outcome in terms of progress for treatment subjects, the cost of providing music therapy to patients could be compared with the cost of the longer period of time in high secure treatment.

Attkisson et al (1992) conducted a review and analysis of clinical services for people with severe and enduring mental disorders, from which research priorities emerged.

This sort of clinical services research involves a broader application of clinical knowledge, gained from the research environment. The goal is to improve quality of care and clinical practice.

Thomas (2003) cites Attkisson (ibid), who states that clinical outcomes at their most basic level are defined by whether people get better as a result of their contact with health services. Priorities that were identified from Attkisson's comprehensive review included the question of how effective services were for individuals with severe and enduring mental illness, and how treatment and rehabilitation programmes could best be coordinated.

The NICE guidelines for Anti-Social Personality Disorder (2010) recommend that the provision of evidence-based treatment and rehabilitative services and the documentation of treatment outcomes are ethical requirements for people who have limited choice because they are incarcerated and receiving treatment in secure hospitals.

Multi-dimensional clinical goals are aimed at improving, treating and curing illness or reducing symptoms; rehabilitative goals are aimed at functional independence; humanistic goals are concerned with well-being; and public safety goals are formulated to prevent injury to self and others. Outcomes should have multiple perspectives so that different viewpoints may be brought together.

With reference to these principles, different goals require consideration in relation to the treatment context of this study. These goals will be referred to in considering which music

therapy outcomes may contribute to a multi-disciplinary approach specifically in forensic treatment settings. Attkisson et al (ibid) specify the following guiding principles:

- The outcome measure must be sensitive enough to document individual differences, which take account of cultural, religious, health and social care needs.
- Outcomes should be designed and measured with standardised assessments, which are statistically validated and with standard designs, which are replicable thereby enabling comparisons with similar studies.
- Outcomes may be measured longitudinally over time, within defined frames of reference.
- Outcomes should be considered in relation to the cost of services, not only in isolation but also in relation to their clinical effectiveness. Thus clinical effectiveness requires rigorous testing.
- Finally, outcomes must be considered in relation to the best available scientific evidence, how the outcomes impact on clinical services and how they relate to policy and legislative reform.

Music therapy may be related to functional independence through extending the individual's range of self-expression and creativity; it may be related to well-being through improved sense of self-worth, and to the prevention of harm to others through risk reduction.

With reference to point 1 of these guidelines, the sensitivity of the selected primary outcome measure must take into account individual differences; this is particularly relevant to this small-scale mixed methods study in which analysis of data from the selected primary outcome measure must be able to detect individual trends of change even if no statistically significant differences are found.

Point 5 of the guidelines refers to relevant scientific evidence. In the area of CAT research, Birtchnell, Denman and Okhai (2004) state that no measures have been developed for determining the presence or absence of maladaptive reciprocal-role relating in CAT despite the clear underlying theory. They implemented a service-based comparison of outcome measures to measure the effect of 16 sessions of CAT compared with psychodynamic psychotherapy. The study sought to compare two outcome measures: the Person's Relating to Others Questionnaire (PROQ2; Birtchnell and Evans, 2004) and the Clinical Outcomes Routine Evaluation (CORE-OM) (Barkham, Evans and Margison 1998). This research indicated that the PROQ2 was fit for

purpose in the present study, because PROQ2 has qualitative domains of relating, which can be both quantified and statistically analysed and which relate specifically to attachment theory. The qualities of the PROQ2 are explained in detail in chapter 6.11.1.

Thomas (2005) cites Clifford (1998), whose model incorporates both clinicians and service users' views (point 2). Thereby, multiple perspectives such as health and social change can be assessed, as well as quality of life as seen through the patients' experience. This study follows this principle by capturing the experiences of both the music therapists and the patients by developing a bespoke semi-structure interview schedule for qualitative analysis (Appendix 5b) and a Music Therapy Patient Satisfaction Questionnaire MT-PSQ (Appendix 5c)

3.2 Use of outcome measures in music therapy

3.2.1 Satisfaction measures

This study is designed as a mixed methods patient preference RCT. The qualitative components include patient satisfaction questionnaires and a semi-structured interview to capture the music therapists' observations and experiences.

There are limited standardised measures in general psychiatric use to evaluate satisfaction of service users. The Client Satisfaction Questionnaire (CSQ-8UK; Attkisson and Greenfield, 1994) was selected as fit for purpose. It had been used previously in the music therapy RCT (Talwar et.al, 2006) for in-patients with schizophrenia. This outcome measure categorises different areas of potential satisfaction which are named as follows: the quality of the intervention and service; whether the individual patient's needs were met; overall satisfaction; and, finally, satisfaction with the information received and the range and choice within the intervention.

Unlike quantitative standardised measures, leading experts in music therapy have developed qualitative measures for specific contexts. These may be designed for outcome or process research. An example of an observational music therapy measure for patients with schizophrenia is the Music Improvisation Rating (MIR; Pavlicevic, 2000). Rogers (2000) devised a table for music therapists to refer to in which she defines the components of qualitative and quantitative music therapy research. She describes the quantitative approach as hypotheses generating and subjective in contrast with the qualitative aspects, which are hypothesis testing and objective.

The present study takes both of the above perspectives in measuring outcomes. A specific Art and Music Therapy Patient Satisfaction Questionnaire (AMT-PSQ;) (Compton and Beeley, 2012) was developed from the findings of Odell-Miller, Hughes and Westacott (2006) in order to capture specific aspects of how the patients considered that music therapy in particular had helped them and how they considered it had helped to create changes within them. This measure was constructed as a Likert scale (see Appendix 3g).

The purpose of the Art and Music Therapy Patient Satisfaction Questionnaire is to collect detailed information from participants about the non-verbal aspects which are not captured in the standardised psychotherapy outcome measures such as the Clinical Outcomes Routine Evaluation (CORE-OM; Barkham, Evans and Margison 1998) or the Attkisson and Greenfield (1994) CSQ. The objective was also to ascertain how acceptable G-CAMT was (in other words, how difficult or at ease the patients felt about it), and what would have helped more in enabling them to get more from the therapy provided; and to further identify domains in which the patients thought the therapy helped them (e.g. self-esteem and relating to others).

3.2.2 Standardised evaluations of music therapy

Music therapy research includes examples of good practice in the use of standardised measures. Maratos, et al. (2008) conducted for the Cochrane Collaboration a systematic review to find out if different models of music therapy were effective in reducing the symptoms of depression. This review identified five studies that met its criteria. The primary outcomes were the Beck depression inventory (BDI; Beck, 1961) and the Hamilton Rating Scales for Depression (HRSD) (Williams 1988)). In keeping with the Attkisson, and Greenfield, (1994) guiding principles, secondary measures included in the above Cochrane review feature social and occupational functioning (Tyrer et al., 2005); self-esteem (Rosenburg, 1979); quality of life such as EuroQol (1996); economic outcomes in terms of cost efficiency of treatment; adverse effects; and overall treatment discontinuation or dropout.

Forensic music therapy is a relatively new area of research, which has developed further since the implementation of the present study. These developments will be discussed in chapter 10.

3.3 Outcomes of interest in forensic music therapy

The overall purpose of treatment for people with mental disorders in the UK who have offended is towards recovery rather than punishment. Recovery may be defined from a variety of perspectives.

The recovery model is an approach to mental health that represents a movement away from pathology, illness and symptoms towards strengths and wellness. Shepherd, Boardman and Slade (2008) describe recovery as building a meaningful and satisfying life as defined by the person themselves. In this respect, this definition is relevant to the qualities inherent in music therapy treatment, which may help a person towards recovery. McCaffrey, Edwards and Fannon (2011) explore the congruence of music therapy with the recovery approach, in particular looking at the meaning of the therapeutic relationship and the potential for growth and change.

Risk assessment in forensic treatment is the constant priority. Quinsey, et al. (1998) name target areas for risk reduction. These include behaviours of patient management and aggression, stability of mental health, reduction of actively psychotic symptoms, addiction issues such as substance misuse, and relational aspects such as life skill deficits, social withdrawal and family problems.

Pollock and Stowell Smith (2006) identified risk potential for the use of cognitive analytic therapy in forensic settings. These authors note that many people who have offended cannot verbalise what a high risk is, and frequently cannot explain what overall risk means. They continue by reminding the reader that these patients are often unable to think about their own capacity to do harm towards others. This is equally relevant to music therapy in forensic settings.

Music therapists have addressed risk management in various ways. Smeijsters and Cleven (2006) reviewed which areas of treatment are important in forensic arts therapies practice across Holland, and which observations, indications, goals, interventions, effects and rationales arts therapists may use. Qualitative, subjective data was collected on-site, with dialogue between researchers and clinicians who summarised the treatment of destructive aggression by identifying the indicators, goals, interventions, effects and rationales for each of the four arts therapies (music, art, drama and dance movement). Indications for music therapy included lack

of aggression regulation, and lack of contact with one's feelings to avoid conflicts. Identified goals were to gain insight, to express aggression and to handle conflict. Interventions included active forms of play with power and status, and exploration of cognitions, feelings and behaviours. Treatment effect included change of feeling and less anger. The question thus may be posed as to what happens to the feelings of anger.

Music therapists working in forensic settings have developed programmes to address aspects of risk such as anger management (Haakvoort, 2002), reduction of self-harm (Hannibal, 2003) and treatment of aggression (Pool and Odell-Miller, 2011). Impulse control is central to risk reduction. It is a novel feature of the present study that it addresses this issue by hypothesising that impulsivity may be reduced as emotional recognition increases with the accompanying ability to self-reflect. This aspect is demonstrated in the following vignette.

A man who had been committed for long-term treatment, having murdered more than one person, began battering overwhelmingly on the drum kit so loudly and deafeningly that even the music therapist's piano playing was overwhelmed. When the music therapist stopped, the patient pointed his drumsticks accusingly towards him for spoiling his fun. The music therapist later described this experience as feeling like he was being attacked, albeit in a wholly unconscious and sadistic offence re-enactment. The music therapist again stopped playing and waited until the patient noticed that he had stopped – this took some time. He then told the patient that he felt as if the patient was attacking him. The patient was absolutely mortified to think that his actions may have been perceived in this way. This enactment helped the patient to start to consider his effect on others and to think about his previously unconscious processes. He eventually progressed to group music therapy and became a more self-aware and considerate group member. This example demonstrates the patient's lack of understanding of what risk means. It has implications for the music therapist in providing for patients a sufficient explanation about the potential risks of emotional overload if multiple overwhelming to overwhelmed reciprocal role enactments occur in jointly created musical improvisation.

The exploration of change and hoped-for outcomes in G-CAMT is concerned with whether or not the patient can develop an ability to connect with and to empathise with his fellow group members. Alternatively, the risk is whether or not uncontrollable fear may overwhelm him, leading to reactivation of his own victim state and the psychological defence of dissociation. These changes may contribute to the

multi-disciplinary risk assessments, which are necessary prior to a patient's move to conditions of lesser security.

As noted by Adshead, Sharmila and Pyszoa (2005), Pollock, Stowell-Smith and Gopfert (2006) and Compton Dickinson (2006), patients who have committed serious offences have both a victim and an offender state. A traumatic response of complete amnesia of, and dissociation from, the offender self-state may occur when past events have been too intolerable to contemplate in people who have multiple diagnoses including personality disorder. The Multi-scale dissociation Inventory (MDI) (Briere, 2002) comprises standardised measures for measuring dissociation, which have been used and tested on the forensic population.

Talwar, et al. (2006), in their exploratory RCT of music therapy for in-patients with schizophrenia, measured symptom reduction on the Positive and Negative Syndrome Scale (PANSS; Kaye, et.al. 1987) and the Global Assessment of Functioning Scale (Jones, et al., 1995). The recommendations of the Talwar et.al (2006) study are that a future explanatory study would be of value in discovering how music therapy works.

This, therefore, was a central tenet in the development of methodology for the present study and in defining outcomes of interest.

3.3.1 Why measure relational changes?

Over the course of forensic treatment, the MDT assesses whether each individual is able to develop within himself feelings of remorse for his own past destructive actions. When the offender patient is able to start to think about his inner world and his past violent behaviour, the hope is that a renewed understanding of the impact of his behaviours on others may develop. This involves recognition of impulsivity and the development of victim empathy. This process often includes recognition of feelings of rejection, abandonment, humiliation, resentment and anger. As psychotic symptoms are stabilised and the treatment develops, insight into and recall of the predisposing and precipitating events prior to the index offence increase. This can be shocking for both patient and therapist as they realise the horror of what in some cases can be recognised as the most horrendous and appalling 'mistake' (Compton Dickinson, 2003; Doctor, 2008).

Precipitating factors of a serious offence frequently include the breakdown of relationships and floridly psychotic episodes. If the patient has killed, an understanding of trauma and loss to the

relatives of a victim may be encouraged through the process of restorative justice (Strang, 2002). This involves repair as opposed to revenge and the development of victim empathy. The question that this poses is what emotional and relational qualities are required of the perpetrator to fulfill this expectation?

Batson, Fultz and Schoenrade, (1987) have demonstrated empirical relations between many forms of prosocial behaviour and empathy. They state that in general, personal distress in an individual evokes a response in the other that is aimed to reduce aversive arousal, though this may not be the case if distressed, bizarre or psychotic behaviour is frightening to the other prior to an offence being committed. Thus the development of empathy must involve mental stability and awareness of those around him. Then the motivation that is evoked by empathy is through understanding the other. This may instead be altruistic, as the ultimate goal seems to be towards the reduction of the other's need, not reduction of one's own aversive arousal.

3.3.2 How do we measure empathy and emotional relatedness?

Jolliffe and Farrington (2004) conducted a systematic review and meta-analysis of empathy and criminal offending which called into question the strength of the relationship between empathy and aggressive/antisocial behaviour. The review identified 35 studies of empathy and offending in which a moderate mean effect size of -0.27 was found, suggesting a negative relationship between empathy and offending. This relationship was stronger for cognitive than for affective empathy, and stronger for younger people compared with older people.

The most striking finding was that the relationship between empathy and offending was reduced considerably after controlling for intelligence, and that the relationship disappeared completely after controlling for socio-economic status. So, these authors considered that either (1) empathy is not causally linked to offending, because low socio-economic status causes both low empathy and offending, or (2) low socio-economic status causes low empathy which in turn causes offending. Feshbach (1978) argued that empathy is a combination of three components: the ability to identify the affective state of the other, the ability to assume the perspective of the other and the ability to share another's experience. Thus, if a person comprehends and shares another's negative emotional reaction such as distress, which results from aggressive behaviour, that individual may be less inclined to continue with that negative behaviour. This aspect holds a challenge for the capacity of empathy in the music therapist in understanding her patient, whatever his offence may have been. The reciprocal role of receiving empathy would be

empathetic to empathized with, through which the patient may experience a positive exchange and feeling from the more experienced therapist, and then try to emulate it.

When reviewing the data in assessing for cognitive and affective empathy, deficits were found in offenders compared to non-offenders. The authors also reported that the relationship between low empathy and offending was relatively strong for violent offenders, yet relatively weak for sex offenders. Thus, the particular offence may be determined by the likelihood or absence of empathy. Jolliffe and Farrington (2006a), in the validating paper for the Basic Empathy Scale (BES), found a negative relationship between cognitive empathy and alexithymia (the inability to comprehend the emotions of others).and total empathy scores (which is a combined score of cognitive and affective empathy), This occurred across both male and female subjects.

The above systematic review incorporated both global and victim empathy measures, and concluded that low cognitive empathy was strongly related to offending, with low affective empathy being weakly related (Jolliffe and Farrington, 2004). This author suggests that this finding, taken in reverse, may have a bearing on whether music therapy increases affective empathy and therefore decreases offending behaviour.

Jolliffe and Farrington (ibid) further question whether an understanding of another person's emotions may be impaired by a lack of understanding of one's own emotions. This might sound obvious to a music therapist, but it has further implications in the role of supervision on professional development, plus the levels of emotional awareness of clinicians who work with the psychodynamic processes of transference and counter-transference. A lack of emotional awareness may questionably impact on how effective they may be as therapists in developing a therapeutic alliance. This is a factor that requires consideration in the present study in terms of how music therapists are supported towards understanding and delivering a new model of treatment, since their understanding is necessary prior to effectively communicating cognitive understanding to their patients.

Defining the difference between empathy and sympathy involves an additional appraisal regarding emotional understanding. Sympathy, it is generally agreed, involves the appraisal of how one feels about the emotions of another. Jolliffe and Farrington (2006) cite Eisenberg and Strayer (1988), who state that sympathy is similar to affective empathy in that both involve a congruent response to the perceived emotions of another. In the case of affective empathy, this reaction is the same emotion as the other person. This phenomenon is relevant because it

involves the process of how people relate and respond to each other. So, for example, one may share and understand another person's sadness without having experienced it. One may feel concern for another person's welfare with sympathy, or share the other person's sadness with cognitive and affective empathy and yet feel that the person deserves that situation – a response that is not sympathetic. Jolliffe and Farrington account for these differences in the construction of the Basic Empathy Scale (see Appendix 3d).

3.3.3. The person's relating to others questionnaire (PROQ2) (Appendix 3a)

Birtchnell's relating theory (1997) explains the relating deficit of patients seeking psychotherapy. In brief, Birtchnell considers aspects of closeness, distance, upperness and lowerness to be advantageous states of relatedness, which can also be found in a simpler form in other animals in their relating behaviour. Each stage of relatedness represents an innate objective that is vital for survival. This theory is compatible with CAT relating theory (Ryle, 2002). Both theories consider that over the course of life, based on social, cultural and familial changes, the learnt patterns of relating which develop in childhood may become archaic and dysfunctional, thereby impairing the ability to respond effectively in the modern adult world.

Birtchnell describes competent and confident relating as positive; and incompetent, ineffectual and insecure relating as negative. If people relate positively in all domains they are considered to be versatile and to have few interpersonal difficulties. One of the effects of psychotherapy is the reduction in negative relating. By identifying areas of negative relating, these may become treatment goals and the focus of the therapy.

The validating paper by Birtchnell and Evans (2004) describes the scales of this outcome measure, which correspond to the octants of an octagon, which is constructed around horizontal and vertical axes, which in turn represent proximities of closeness and distance from others.

3.3.4 Observational measurements

There are similarities between relating theory and research on interpersonal theory (Leary, 1957; Keisler, 1983). The latter is based on the interpersonal circle (Blackburn and Glasgow, 1993) which forms the basis for a context specific observational measure.

The chart of interpersonal reactions in closed living environments (CIRCLE) (Blackburn and Glasgow, 1993) is a bespoke, validated and reliable tool composed of an observation scale,

which permits an observer to record an individual's interpersonal style as it is exhibited within an institutional context. The circle has its origins in a 31-item nursing observation scale (NOS), developed by Blackburn in 1979, drawn on the study of patients in a high secure hospital. The items produce two factors, which are called aggression psychopathy and social withdrawal. A subsequent study included ratings of Cleckley's (1941) criteria of psychopathy and other personality measures, the study suggest that these two dimensions correspond to the hostile dominant and hostile submissive axes of the interpersonal circle.

There are differences between the interpersonal theory of the CIRCLE and Birtchnell's relating theory. The CIRCLE represents normality at the centre and abnormality is represented at the periphery, CIRCLE shows abnormality as an extreme version of normality. Bipolarity is related to the mathematical structure called the circumflex, in which attributes located on one side of the circle are the bipolar opposite of those located on the opposite side.

The CIRCLE relies on staff observations on the ward as an alternative to self-report measures within the treatment groups. It assesses personality in terms of dimensions of power or control, dominance versus submission, and affiliation hostility versus friendliness or nurturance. Blackburn and Glasgow (ibid) state that as a result of genetic factors and developmental experiences people tend to develop a distinctive interpersonal style. This fits with CAT theory in that patterns of relating may become fixed and dysfunctional in terms of Traps, Snags and Dilemmas (Wilde McCormick, 1996; Denman, Birtchnell and Okhai, 2004).

The more pronounced or extreme style a person has, the less he relies on behaviour from the opposite parts of the circle. Hence rigid and inflexible behaviour and rigid interpersonal style is the result, which produces reactions that are contextually inappropriate and aversive to other people. This notion is consistent with the current five-factor model of personality disorders as inflexible traits, which are characterised by interpersonal dysfunction (Costa, Paul, and Widiger, 1994). The CIRCLE acknowledges the big five dimensions of personality as does the validation paper of the BES.

Blackburn and Glasgow (2006) state that there have been very few studies that look at interpersonal style as a predictor of institutional violence. They compared the CIRCLE with the psychopathy checklist: screening version (PCL: SV); identified a superordinate component which is incorporated into the interpersonal circle; and found that the subscales of the CIRCLE were statistically better than the PCL: SV at picking up minor infractions such as verbal abuse.

Blackburn (ibid) concluded that the staff ratings of interpersonal style in the domains of dominance, coercion and hostility on the CIRCLE were useful in identifying those patients who may engage in minor disciplinary infractions. This is useful to this study, in which minor changes and incidents are more frequent in the treatment setting than major incident reporting events.

The CIRCLE, therefore, makes a novel contribution to music therapy research in forensic settings in which no external observational measurement that is context specific has been used in any of the research reviewed to date. The CIRCLE can help towards evaluating meaningful changes between the treatment and control groups' behaviours outside treatment groups.

All the outcome measures used in the present study have been referred to in this chapter. Their properties will be described in Chapter 5 in relation to the hypotheses.

Chapter 4 The Development of the Treatment Approach and of the Treatment Manual

In this chapter, 4.1 describes why a research and treatment manual is useful towards developing the evidence base and for a research study. 4.1.1 describes the complex psychodynamics of a high secure hospital and how and why a manual is designed for this treatment environment and context. The clinical risks are then described. 4.2 then explains the rationale of why changes in the overall treatment approach in high secure treatment led to developments in forensic music therapy, further modifications and the novel aspects of G-CAMT. 4.3 describes the integration of music therapy with CAT and how G-CAMT was developed as a group-work model. This is followed by a description of the modelling stage and the pilot project. Finally the treatment manual is provided for the main study.

4.1 Why develop a research treatment manual?

There are organisational, clinical and research reasons why a manual for a complex treatment intervention is valuable. Craig, et al. (2008) state that the MRC guidance for developing a complex intervention (Campbell, Fitzpatrick and Haines, 2000) has been widely accepted in terms of how to recognise and adopt appropriate research methods. Summary points from the Campbell, Fitzpatrick and Haines guidance (ibid) are that the development of a complex intervention has several stages, and that an understanding of the processes as well as the outcomes is important. This guidance highlights that complex interventions are best tailored to local circumstances, rather than standardised. These aspects will be considered firstly with reference to the treatment context and psychodynamics of a secure hospital and then in terms of the processes and outcomes based on the evidence and theory which preceded the main study. This guidance has been highly influential bearing in mind the practical and methodological problems that have to be overcome in evaluating a complex intervention. Craig, et al (2008) have updated this guidance, because since it was published much experience has been gained through both conventional and innovative methods.

4.1.1 The psychodynamics of the secure hospital setting

This section will begin with reference to the work of recognised experts in the field. Dr Gwen Adshead is a consultant psychiatrist, psychodynamic psychotherapist and group analyst who draws from attachment theory and mindfulness-based cognitive theories. Her specialism is in

understanding the serious mental disorders that bring patients into contact with the law, and subsequently into secure hospital treatment through the criminal justice system.

Adshead (2012) considers the implications for people being cared for and people working in secure hospitals. She explores the dynamics of these organisations, and the parallel processes which occur in terms of attachment patterns, and the developing psychological defences of both the staff and forensic in-patients. She reminds the reader that almost the only services that continue to provide long-term in-patient care in the current NHS, are forensic psychiatric services. The reason for this is that the patients who reside therein have frightened others. Therefore, feelings of fear can permeate the entire environment, through which organisational anxieties and social defences develop (Menzies Lyth, 1960).

These processes are relevant to why a context-specific music therapy treatment manual is necessary in the secure hospital treatment setting, because the underlying theories of the model are also based in attachment theory and how humans relate (Birtchnell, 1993). Adshead (2012) explains how psychological defences build up in response to these organisational anxieties that arise in caring for people who may elicit negative feelings of disgust, shame, hostility and rage. These feelings will inevitably be communicated between patient and staff groups, albeit unconsciously, and within all levels of the institution, including the management teams. She refers to this process as emotional contagion, which she describes as inevitable, non-conscious and non-verbal. She highlights that this is important to consider for the health and well-being of therapists and nurses. The above explains that there are attachment implications for how people relate within a closed living environment. For the majority of patients receiving treatment within secure hospitals, there are also deeply rooted attachment dysfunctions from long before they committed an offence.

Adshead (ibid) cites Dell and Robinson (1988), who state that patients whose offences may be inexplicable, or whose disorders are particularly resistant to treatment, may remain as in-patients for many years beyond the average length of stay. This concurs with the experiences of this author at the research site. The average length of stay for a patient in a high secure hospital is approximately six years, though there are patients whom this author has treated who have been incarcerated for over three decades – during most of their adult lives.

The NHS Institute for Innovation and Improvement (2008) seeks to reduce the length of stay (LoS) for hospital admissions in order to release capacity in the system. This involves proactive

planning of the whole process of care as well as active discharge planning. With patients who have committed violent offences the highest concern is therefore that of risk reduction and consideration of how this may be achieved through prosocial behaviour.

In support of the fact that there are higher levels of insecure attachment in psychiatric service users, Adshead (2012) further cites research by Bakermans-Kranenburg and van IJzendoorn (2009). These authors compared attachment patterns in non-clinical and clinical groups. 58% of the non-clinical participants were able to seek comfort when distressed and to ask for help, in comparison, less than 20% of the clinical group were rated as having secure attachment.

Adshead (2012) explains that humans are social animals who in order to live together need to develop a 'social mind' through the capacity to appreciate others. This process of sociability can be inhibited by impairments of attachment which are frequently rooted in traumatic experiences in childhood. Liotti and Gumley (2008) explain how disorganised attachment patterns and dissociation develop in people with schizophrenia, and thus emotional recognition is impaired. Furthermore, the phenomenology of schizophrenia includes persecutory delusions which can contribute to the development of a victim state of being.

Patients with a primary diagnosis of schizophrenia are the population under investigation in this study; therefore, understanding is required of their inner world and experiences. Frequently, owing to early trauma, which disrupts the development of secure attachment patterns, those who have offended have little autonomous control over their instinctual drives. Lodrick (2007) explains this process as vital knowledge for everyone who works with psychological trauma. She describes the instinctual drives in terms of the five Fs: the initial 'fight', 'flight' and 'freeze', to which she adds 'friend' and 'flop'. She explains that the 'friend' strategy is the earliest defensive strategy in that it is initiated through the cry of the infant to elicit the caregiver's attention. When mistrust develops through inconsistent care, neglect or abuse, the 'friend' strategy is damaged. When fear is pervasive, male patients in particular may instinctively respond with the fight mechanism, whereas the female instinct is most commonly to take flight and to turn the feelings of aggression within themselves towards self-harm (Motz, 2008). For both men and women this results in disconnection from others

Over time, with the constant firing of stress responses, hyper-vigilance develops for people who suffer with schizophrenia. This is explained through the stress vulnerability model (Nuechterlein, et al., 1984). Stress vulnerability leads to poor impulse control and ultimately the

development of a perpetrator self-state, as patients are unable to respond in a normally assertive way. The neurological processes are overactivated so that a procedure occurs. The instinctive fight or flight impulses are activated before the mindful cognitive processes of thought can mediate the response. The ability to recognise the feelings that are associated with the thought that motivates subsequent behaviours is impaired, thus feelings of anger become aggressive behaviours.

Pollock and Stowell-Smith (2006) describe the most frequent RRP and self-states in forensic treatment to be those of the victim and the offender. The assertive response is bypassed, and aggression as a behaviour may result because an individual is unable to recognise and name his feelings of anger. In CAT terms these responses are named as relational Traps (Ryle and Kerr, 2002), which manifest in the form of repetitive procedures of relating that in earliest days were the only available options. Thus,

Siris (2000) explains stress vulnerability with direct reference to patients with low motivation who suffer with schizophrenia and depression. He clarifies that stress vulnerability can be psychosocial or biological. He states that traumatic interpersonal experiences, more longitudinal psychic stresses (such as chaotic, abusive or high 'expressed emotion' environments), and lack of opportunity to develop adequate compensating coping skills are all examples of psychosocial stressors. This evidence all points towards the need for an attachment-based form of forensic music therapy, which may help to ameliorate dysfunctional attachment patterns.

The multiple aetiology and complexities of schizophrenia in combination with the impact of life stressors can result in feelings of guilt or inadequacy which may lead to withdrawal and isolation from the world. Hence, from the perspective of both the sufferer and others it is not conducive to the development of group or community feeling. The result is poor communication, which can leave sufferers feeling very frightened. They are avoided and ostracised by the community and they reciprocate similarly. They isolate themselves, often in response to their symptoms, which may include extreme, paralysing anxiety and persecutory delusions too dreadful to talk about. Those around them may then perceive them as frightening. The above all supports the presence of the reciprocal role of frightening to frightened: this is a polarised reciprocal role, which can be seen to operate between the hospital staff and the mentally ill individual. This is further compounded by lack of understanding of different cultural norms.

In containing people with severe mental disorders, the dynamics of an institution may become toxic and counter-productive, leading to feelings and behaviours of contamination among staff. Hervey and Odell-Miller (2013) explore staff perceptions of the introduction of a music therapy service to a new unit for people with severe personality disorders. They noted that the psychodynamic model, more than the music itself, could create problems for staff.

Group dynamics in the present study are considered from the social point of view within the established theories of Foulkes (1964) and the individual psychology of Alfred Adler (1964). Both Foulkes and Adler are considered to be founding fathers of attachment theory in terms of social and human development.

Adler's psychoanalytic theories have contributed to the social theories of relating as can be seen in the development of the CAT model. Adler's (ibid) discovery of the inferiority complex can help in understanding why patients may choose to retreat. In the high secure hospital environment, one patient may retreat in response to another who strives to dominate and assert superiority. In effect, a pack instinct operates on all male secure hospital wards. There is an unspoken, largely unconscious pecking order that develops at mealtimes, which reflects instinctual drives of male dominance within the group hierarchy. Group therapy can ameliorate these patterns through recognition of dominant and narcissistic responses.

Patients may be encouraged to find meaning through social interest in making music and becoming involved with others by forging connections and commonalities. Watson Bragg and Jeffcote (2003) describe an example of this in an interdisciplinary time-limited group-work model of music and art therapy in which the seeking of commonalities can be found as well as engagement and interest in the wider community.

In considering the therapeutic reworking of impaired aspects of child development in a mature adult, social learning in a non-didactic sense from the more experienced other is the central concept of Vygotsky's (1978) activity theory. These theories underpin developments in the CAT model. The therapeutic process that evolves from this concept, relates to the level of meaning that is created within the joint activities that may occur within the therapeutic relationship. Wertz (1985) explains 'meaning' as being found through 'intentionality', which occurs through the consciousness of the other. He states that meaning and intentionality are fundamentally relational in that consciousness and the object become a totality, thus joint activities can have meaning. A process of attunement can occur in any sensory modality and as

such is not dependent on verbal communication, therefore attunement, meaning and intentionality can be applied to non-verbal relating in music therapy. This may occur in relationship to a musical instrument, which may become an object of meaning, and to the therapist through the development of meaningful musical dialogue. Stern (1985) describes the relational exchange between mother and infant as a process of ‘affect attunement’ which is achieved through a mirroring effect that may be emotionally attuned and congruent, or non-responsive to the cries of the infant. This relational process creates a connection, which can be applied and mediated non-verbally in a similar manner in music therapy through the modalities of sound, action and vision. Robarts (1996) describes an example of the application in music therapy of Travarthen’s (2003; 2007) theories of interaction between mother and infant. Trevarthen’s theories have since been considered in the development of CAT practice in which visual modalities are incorporated in jointly creating the diagrammatic tools and meaningful artifacts of therapy (ACAT Annual Conference, 2014). Thus it may be seen that there are commonalities between underlying theories of CAT and music therapy, which make an integrated model a distinct possibility.

4.1.2. The importance of a treatment manual for music therapists in forensic settings

Menzies Lyth (1960) explains how clinicians may get caught in a dilemma between their caregiving and therapeutic roles, the purpose of both of which is to engage with the patient. Their conscious and unconscious anxieties may impel staff to withdraw from contact by ostensibly being involved in practical tasks. This was a motivating factor towards developing an evidence-based treatment manual which could help music therapists feel safe enough to engage with patients whose behaviour and offences could elicit profound feelings of fear, revulsion and disgust.

Menzies Lyth (ibid) explains how these social defences enable nurses to manage feelings of uncertainty, guilt and anxiety, but how these feelings can impair the abilities of staff to fulfil their roles effectively. This is equally true for music therapists, although their patient contact time is generally limited to session times. However, the level of ward contact time for music therapists requires consideration in terms of how it may help them to create an initial therapeutic rapport with a patient and yet maintain effective boundaries (Compton Dickinson and Benn, 2012). When unspoken anxieties arise in a secure hospital clinical situation, a parallel process can occur which is mirrored in other levels of the hospital hierarchy. Everyone in an MDT is

playing some sort of therapeutic role, and whilst these differ greatly, the needs of nursing staff and how nurses may be able to help or hinder the music therapist require consideration.

Menzies Lyth's research found that if feelings could not be expressed, greater anxiety would result. One purpose of music therapy is to express emotions that may be too difficult to articulate in words. This aspect has implications for how interdisciplinary work in music therapy may be undertaken. If the music therapist is aware of these underlying anxieties there is the possibility of helping staff members in their levels of participation in a forensic music therapy group.

Compton Dickinson and Benn (2012) discuss the impact of staff whose role it is to observe patients in their therapy sessions in secure hospitals without participating. Consideration is given as to how the music therapist can manage to elicit a relevant amount of engagement from observers, which may put the patient at ease and help the nursing assistants to fulfil their role of keeping everyone safe from harm. Compton Dickinson and Souflas (2012) describe an example of staff participation that worked in clinical practice when a member of the patient escorting team expressed an interest in operating the mixing desk in the music therapy room. His level of participation helped everyone when he took on the role of sound engineer in which he felt confident and valued and in which he knew his own boundaries. To participate in group improvisation, however, may bring up too much emotion for the staff member unless the music therapist guides him.

Music therapists' anxieties in treating people who have committed violent offences frequently relate to questions of how to develop a more intimate form of musical communication with the patient, the objective of which is to enable the patient gradually to become able to self-reflect and think about what was previously unthinkable. In secure hospital treatment the central therapeutic issue that is difficult for patient and therapist to think about is the index offence. The ability to reflect quietly and safely on why an act of violence against another person has been committed can be facilitated through music.

Bunt (1994) explains how this non-verbal process of musical communication can occur through the aesthetic qualities of a simple sound played by the music therapist in response to the atmosphere of a group. The atmosphere can then change in the music therapy room in response to the unique qualities of a sound, its duration and its dynamic as it rises and falls. The pitch of the sound can match the vocal range of the human voice, and the music develops organically

through rhythm, melody and harmony. Through this, the mind can imagine a scene or a journey, and metaphor can be used to more easily work with what was previously intolerable.

4.1.3 Risks to the music therapist

The emotive nature of making music with individuals who have committed violent acts against others and who are more rapidly provoked owing to their faulty attachment patterns and traumatised histories, can be dangerously overloaded or categorically denied through dissociation. If dissociation occurs in the music therapist, which may be similar to that which the patient himself may be suffering and for which treatment is required, there is a risk of either disconnection or over-identification. This creates a paradox in that both patient and therapist feel detached from their own feelings, yet toxically bonded. The music therapist may find the counter-transference so intolerable that feelings may be projected on to the arts therapies team or the MDT, leading to divisions, unhealthy pairings and internal attacks. In this respect, the manual is designed to guide and reassure patients and therapists and as a source of information for the MDT through which joined up treatment can progress safely through stages.

Annesley and Jones (2013) highlight the need to remain aware of both the victim and the perpetrator self-states. If the offence is denied, the work is not progressing within the overall objectives of the MDT treatment. The music therapist may remain unaware of the risks of harm if unable to tolerate or think about the perpetrator self-state of the patient. Working with the patient's victim state only can be a defence against acknowledging disturbed and unpleasant dynamics in which a patient may be trying to groom or seduce his therapist through his old patterns of relating in the way an abuser previously related to him. Compton (2007) describes the varying enactments of these abusing-to-abused reciprocal roles and how they operate in society.

Aiyegbusi (2012) cites the Leicestershire inquiry (Kirkwood, 1993) in which Frank Beck was convicted of sexual assaults on children in residential care homes with whom he had used a treatment approach called 'regression therapy'. This is relevant to the present study because it was a misuse of the psychoanalytic principles of Balint (1968). High-profile examples of institutional abuse (such as the one above, which led to a public inquiry) can lead to suspicion among nursing staff of any form of therapy which involves regression in the psychoanalytic sense. Hence, a structured manual may help in

managing risk of violence and in supporting music therapists in techniques to mediate emotional processes within safe boundaries, which may create the conditions for internal change for the better, as well as reassuring nursing staff.

4.2 The music therapy approach and attachment theory

Western psychology emphasises the individual need to 'get better' (Risby and Van Sant, (2001). This attitude may in itself influence an individual's decision to retreat from society in order to find healing from within. This may be a contributory factor to the self-isolation that can lead to psychosis and breakdown and ultimately to the index offence. It also explains the difficulties in engaging this patient group in treatment. Bowlby (1988) postulated that people who suffer insecure attachment as children may become compulsive caregivers as adults, thereby choosing the caring profession. Adshead (2012) cites Norton (1996) and Dozier, et al. (2001) in explaining how this combination has serious implications in forensic residential settings where psychiatric patients find it hard to form attachments owing to the high prevalence of insecure attachment; thus, forming and maintaining therapeutic relationships is difficult.

Birtchnell's (1993) relating theory explains how attachment to others develops out of survival needs, and that an individual who feels under threat will seek closeness to a perceived stronger individual who is less vulnerable. In this respect Adshead's (2012) approach is similar in that she cites George and Solomon (1996), who note that such behaviour is most noticeable when people are afraid, exhausted or sick and are seeking comfort and care. This concept is discussed by Shore (1994), who demonstrated that attachment bonds result in neurochemical changes in the prefrontal cortex where feelings are regulated both consciously and unconsciously.

The above theories have implications for music therapy treatment where there is the opportunity for movement around the room from instrument to instrument, thereby creating distance, as well as the opportunity for dialogical sharing in close proximity. The group hierarchies, commonalities and sociability may then develop along group analytic principles through which the music therapists can observe each individual's needs for closeness and distance.

It is rare to have the opportunity in secure hospital treatment to consider genuine therapeutic use over the longer term of the British object relations school of psychoanalysis (Gomez, 1997). Balint was a member of this school of thought, which developed in the United Kingdom (UK) from the psychoanalytic theories of Freud (1910). Balint's theories (1964) are relevant to the

development of the treatment manual, since this author had previously considered their application from a musical perspective (Compton Dickinson, 2001b). This psychoanalytic method due to the prolonged nature of treatment, may now be impossible to deliver within secure hospital settings owing to the move towards time-limited interventions within staged interdisciplinary forensic treatment interventions. Therefore modifications towards developing a context specific form of forensic music therapy treatment began through single case study research. This was the starting point of the practice-based evidence (Margison, et al., 2000), which preceded the development of the manual.

When people are emotionally damaged through insecure attachment, they are less able to mediate and regulate their responses of proximity, or feelings such as anxiety, distress or anger, owing to impairment of affect regulation (Stern, 1985). According to Bakermans-Karenenbunrg, 2003), cited by Adshead (2012), those with disorganised attachment patterns as children frequently develop into troubled adolescents who suffer dissociative phenomena and psychotic thinking. Compton Dickinson (2001b) demonstrates the value of music therapy intervention in early onset psychosis.

‘Jacob’ was admitted to a medium secure unit after a violent attack on his mother, yet he was fearful of himself and others. He was diagnosed with Asperger’s syndrome, and he was suffering the prodromal stages of schizophrenia in which florid psychosis was developing. The treatment approach was psychoanalytically informed, with music therapy supervision from a psychoanalyst who was also a music therapist. In this way the music therapist was able over a period of 18 months to facilitate this young man’s psychoanalytic regression to a child state that preceded verbal communication. The patient and music therapist experienced a state of peaceful silence together which met the criteria specified by Balint (1964) as characteristic of the fixation point which he called the ‘harmonious mix up’. Jacob gradually came out of the regression. He moved from silence to a babble language, which the music therapist was expected to understand and through which Jacob discovered the ability to be musically playful within the therapeutic relationship. Only then did Jacob become able to express himself in words rather than acting out with violent behaviours.

A secure internal attachment system enables the individual to reach out to others and to ask for help, whereas insecure people may show abnormal responses and behaviours when distressed. A key moment in Jacob’s treatment as he came out of regression was when he asked the music

therapist: 'Is this a secure unit?' Jacob at this point was able to have a feeling of internal containment and safety rather than to fight against the security procedures of the hospital system.

Adler (1964) considered social feeling as central to personality development. He was a pioneer in emphasising the psychodynamic role that family structures play in child development, and in this respect his psychodynamic view of social learning is compatible within a developmental cognitive analytic approach in forensic group music therapy.

Ryle (1991) acknowledges the value of object relations theories in his Procedural Sequence Objects Relations Model (PSORM). This facilitates a cognitive understanding of self-states and RRs which began in childhood and which perpetuate dysfunctionally in the different social and cultural circumstances of adult life. Ryle devised the use of sequential diagrammatic reformulation (SDR) to enable the patient to map the dysfunctional ways of relating that he originally developed in order to cope effectively with the original difficult situation.

4.2.1 The clinical rationale for a specific music therapy approach and treatment manual

If a person feels further threatened and has been traumatised in the past, regardless of gender, he/she may dissociate and encounter the 'freeze' response, in which a common experience is of not feeling entirely present. This is described in the self-states section of the CAT psychotherapy file. Wilde McCormick (1996) creates a table of these 32 different self-states, many of which indicate dissociative traits such as feeling like a zombie, cut off from feeling and others – being disconnected. To recognise these states can be a relief for the patient (Compton Dickinson, 2006).

It is common for people to struggle to find words when in a dissociative state. Compton Dickinson (2006; 2013) describes this in the case of the 'lost boy', in which 'Colin' recognised a profound feeling of sadness, which was elicited non-verbally through listening to a sounding bowl (Kaye, 2014). Colin then dissociated from this intolerable state of sorrow, switching to another intense feeling when playing in dialogue with the music therapist on the sounding bowl. This characterised a shift to a different self-state of potentially out-of-control rage. This case study demonstrates how music therapy may provide a catalyst to undo the stuck-ness and fear which leads to dissociative experiences that constitute a psychological defence to the death instinct. This process involves the risk that a violent response may erupt, so it must also have

structures to enable the therapy to continue safely, with containment and attention to risk reduction. Kellett (2005) describes how sudden gains can be made through the use of specific tools in cognitive analytic treatment for dissociative identity disorder. This is relevant to the present study in considering how to help patients to recognise their different self-states, in particular to reavow their victim and their offender states. Thus, a manual was designed to incorporate these aspects of patient presentation and to work towards effective therapeutic interventions whilst managing the risks of harm.

In the modern NHS an interdisciplinary approach is necessary in secure hospital treatment so that a multi-disciplinary treatment plan can be designed to meet each patient's needs. The term interdisciplinary is defined within the NHS Knowledge and Skills Framework (2004) as 'developing a coordinated, cross discipline team approach to achieve agreed outcomes in a structured way' (Skills for Health, 2004). This involves the ability of professionals to think flexibly, to understand and appreciate differing perspectives and methods

For acceptance and mutual learning to take place a shared language was needed in which multi-disciplinary teamwork could develop comfortably. Psychological interventions were already well established in the cognitive behavioural and dialectical behavioural models. These psychological interventions are focused around offence-related treatments that include mental health awareness, arson, sex offender and violent offender treatment programmes.

Purely psychodynamic music therapy had given rise to staff concerns that unconscious processes were aroused, which led to difficulties of understanding and management for staff on the ward if (or when) patients started to change (Compton Dickinson, 2004; Hervey and Odell-Miller, 2013). Furthermore, in line with NICE guidance (2010), the overall multi-disciplinary treatment approach no longer supported long-term engagement with one therapist only, which was deemed to risk the therapist becoming 'special' to the patient rather than the patient discovering that endings of treatment can be tolerated within pre-planned timelines. Therefore, with the ever-increasing demand for evidence-based practice (Duggan, et.al. 2006), as well as economic concerns over cuts being made to services lacking a robust evidence base, an integrated music therapy model was needed if the music therapy service as a whole were to survive. The model had to be acceptable for use within the work streams of integrated multi-disciplinary Treatment Pathways. (Appendix 2c)

In forensic treatment, relational security – as opposed to restraint – involves joint ownership and participation between patients and staff in which the patients too can feel helpful and helped, thereby raising self-esteem and self-respect and reducing stigma. This involves the patients' collaboration in jointly formulating their treatment aims in relation to the rest of their MDT programme. The development of trust and rapport is essential to achieve this goal.

The clinical purpose of the manual is to guide and support music therapists – who are working in a clinical environment that can be frightening and claustrophobic – towards safely achieving these objectives by developing their techniques and skills in music therapy for the treatment of violent and dangerous patients.

4.3 A manual for research

The value to an outcome research project of developing a manual is that it facilitates treatment adherence by the therapists to the independent variable as well as to consider the components therein, by which changes may be attributed to the treatment under investigation rather than to mere chance (Craig, et al., 2008).

Campbell, Fitzpatrick and Haines (2000) states that to define the components of the intervention is the first phase of research design and that the underlying mechanisms require explanation as to how they will influence outcomes. Evidence can then be provided which will predict how the active ingredients relate to and interact with each other. Thus, first the active ingredients of G-CAMT were categorised in the table below in relation to the criteria stated in the MRC guide.

In his summary, Campbell (2000) states that the reports from studies that are complex interventions should include a detailed description of the intervention to enable replication, synthesis and wider implementation. By having a manual for the delivery of the treatment intervention, the possibility remains for further opportunities to develop the evidence base from the feasibility stage to a future multi-centred RCT.

Table 4.1: Aspects and components (MRC Guidance, 2007) which make G-CAMT a complex intervention.

Aspects that make an intervention complex	G-CAMT complexities
The number of interacting ingredients:	<ol style="list-style-type: none"> 1. Jointly created musical improvisation – this involves physical movement and action 2. Sensory absorption of sound and vibration 3. Verbal dialogue 4. CAT tools: the psychotherapy file sequential diagrammatic relating procedures; closure letters 5. The therapeutic relationship 6. The group dynamics
The number and difficulty of behaviours required by those delivering the intervention:	<ol style="list-style-type: none"> 1. To follow a treatment manual 2. To adhere to the treatment manual 3. To use specific verbal techniques and visual prompts 4. To be a competently trained music therapist
The number and difficulty of behaviours required by those receiving the intervention:	<ol style="list-style-type: none"> 1. To discover how to engage creatively on musical instruments 2. To engage in group-work treatment 3. To commit to the duration of treatment 4. To engage in verbal dialogue and with group issues 5. To understand issues of informed consent

<p>The number of organisational levels targeted by the intervention:</p>	<ol style="list-style-type: none"> 1. MDTs in medium and high secure sites 2. Several high secure wards for the main study 3. Management teams 4. Local ethics committees 5. National ethical standards and procedures
<p>The degree of flexibility or tailoring of the intervention:</p>	<ol style="list-style-type: none"> 1. The music therapist requires clinical autonomy, whilst following a treatment manual on a weekly basis, and will ascertain within the group when verbal or non-verbal musical interaction is required. 2. The duration of improvisation may be tailored through music therapy techniques by the music therapist. Thus ensuring a musical dialogue and emotional regulation. 3. Improvisation will be evaluated through audio analysis of random sessions and in supervision and through observational process measurements. 4. The therapist must refer to the treatment guidance and manual.

<p>The number and variability of outcomes:</p> <p>Social functioning: interpersonal relatedness</p> <p>Degree of empathy for others</p> <p>Severity and duration of dissociative experiences</p> <p>Impulsivity</p> <p>Ward-based observed behaviours</p>	<ol style="list-style-type: none"> 1. Eight discrete domains of potential change in relating as measured on the primary outcome measure: The Person's Relating to Others, PROQ2 (Birtchnell and Evans, 2004) 2. The Basic Empathy Scale (BES) self-report (Jolliffe and Farrington, 2006). Cognitive and affective empathy and total empathy scores 3. Multiscale dissociation inventory professional manual (Briere, 2002) Domains: Emotional Constriction and Disengagement 4. Risk of harm to self or others 5. The manual for the chart of interpersonal reactions in closed living environments (CIRCLE) (Blackburn and Glasgow, 2006) Domains: Hostility, friendliness, sociability and withdrawal
---	---

4.3.1 Group therapy concepts as applied in the manual

The theories of Foulkes (1964), which underpin Group Analysis, inform the development of Group Music Therapy (Davies and Richards, 2002). Foulkes (1964) regarded the social functioning of groups as basic to human existence because we are all born into groups, belonging to a greater or lesser degree to family, cultures and society. Through these influences the individual's life may be shaped both consciously and unconsciously. Life within the culture of the therapy group may help to reshape the individual because the analytic therapy group is like a microcosm reflecting the culture of the wider organisation and society within which the group functions.

The spontaneous nature of improvisation facilitates the expression of emotions and recognition of feelings that arise during the music therapy session. Group analytic concepts operate within G-CAMT, (Richards, Davies and Barwick 2014 pp.133-136). Yet the time-limited nature of the model requires additional CAT tools, which were developed in the piloting stages to facilitate working safely towards closure of the course of treatment with the group analytic framework.

Roberts (2013) highlights the group-work treatment challenges of Foulkes's model with patients who are incarcerated and removed from mainstream society. She recognises the difficulties for these patients in developing intimacy owing to their highly disturbed attachment patterns. Furthermore, there are different social norms within the community of a high secure hospital and this presents challenges in the treatment aims of recovery and normalisation.

Foulkes (1948) suggests that 'the deepest reason why group analytic patients can reinforce each other's normal reactions and wear down and correct each other's neurotic reactions is that collectively they constitute the very norm from which, individually, they deviate.' In forensic treatment, however, the patient 'norm' may be viewed as different from the external norm. These patients are already stigmatised, as they are deemed to present a danger to society since they have already deviated from the social norm by committing a violent offence. The treatment challenge is the 'index' offence for which each individual is committed to a secure hospital. Patients are not encouraged to discuss their offences between themselves on wards. Therefore, the music therapist must create a different sort of safe therapeutic environment where patients can feel able to reflect on why they are undergoing hospital treatment. This therapeutic process almost always involves the reavowing of unpleasant, dissociated feelings, which carries with it the risk of violence.

4.3.2 Pilot stages of implementation

The framework for developing a complex intervention (Campbell, Fitzpatrick and Haines, 2000) sets out key stages in this systematic process. These were applied to the overall study by firstly identifying the evidence base, then developing the theory, modelling the process and the outcomes, exploring the feasibility of a main study by testing the procedures through piloting, considering recruitment and determining the sample size from the pilot studies.

Implementation of an ethically approved study was planned after establishing efficacy through a single case series, which is cited in the NICE scoping document for the treatment of antisocial personality disorder (2007). The objective was then to test the clinical effectiveness of G-CAMT and to understand the change process. Monitoring and longer-term follow-up of patient progress was subsequently undertaken. This modelling stage took place over two years in a high secure hospital as part of service development.

The purposes of the G-CAMT modelling group were as follows:

1. As a modelling exercise to develop the cognitive analytic music therapy (CAMT) model from an individual to a more cost-effective group intervention.
2. To assess the feasibility for other music therapists to deliver this model.
3. To evaluate changes in relating across time, at pre- and post-treatment, for the participants (N=5) using the Person's Relating to Others Questionnaire (PROQ2; Birtchnell and Evans, 2004).

The results:

- Confirmed acceptability to service users and MDTs across diagnoses.
- Recorded positive changes in relating in specified domains of the selected primary outcome measure for men with severe mental illness and men with severe personality disorders.
- Confirmed that a group format of mixed-diagnoses male patients was feasible.
- Confirmed that this model was feasible for other music therapists to deliver.

Over the course of the sessions in pilot 1, members of the group were able to collaborate and think with the music therapists towards developing a diagrammatic map, which was drawn on a flip chart week by week. In CAT terms this is known as the sequential diagrammatic reformulation (SDR). This visual aid mapped out and named the reciprocal role procedures that were enacted within the group, thus aiding recognition of individual relating procedures. The patient could then reflect on how these roles perpetuated, but may not actually be relevant to the current situation. In this way, focused verbal material was generated which led to greater insight for the individual. The flip chart was used to build up a visual image in the form of the diagram, which showed common ways that group members perceive themselves in relation to the group as a whole. This included the offender and victim states. In this group it proved very useful in helping these men to have a sense of belonging to the group and it provided them with a structure by which to think about how to separate from the group as closure approached.

The group as a whole struggled with an analytic closure in which the mourning process could be worked through. Separation anxieties increased, and in retrospect some malignant mirroring occurred in that all the annihilating forces became located in one member. This increased fears, and therefore risks, to all concerned. However, the group was able to engage in a cognitive analytic closure process, which at a group analytical level may be viewed as a compromise, but

in the patients' view provided each member with structure through the task of writing a closure letter.

Each member was invited to write a closure letter to read to the group in the final session. As considered in supervision, three months of preparation preceded the closure. Individuals shared in their letter (or poem) significant memories of each person and what he had meant to them. The group members used the closure process in different ways, and both therapists also wrote closure letters with a paragraph for each member and for each other. This project was subsequently published (Sleight and Compton Dickinson, 2013).

Pilot 2 followed from the modeling stage of Pilot 1. (Sleight and Compton 2013). It was implemented over a 20-week treatment period. The participants were monitored during a control period prior to implementation of the intervention. The treatment was delivered to a prototype manual (Lawday and Compton, 2013). PROQ2 was administered at the start of the control period, at the start of treatment and at the end. In this way the participants acted as their own control.

Objectives:

- To evaluate changes in relating to self and others, comparing the outcomes of the treatment period with those of a TAU period, using the subjects as their own control.
- To test the feasibility of a draft treatment protocol.
- To test the acceptability of treatment with female subjects.
- To develop an interdisciplinary approach to integrate G-CAMT into a DBT treatment programme (Linehan, 1993).

The intervention comprised an 8-week control period, followed by 12 weeks of treatment.

Measurements were taken at a baseline prior to the control period, then again at the start and the finish of the treatment phase. Follow-up was not feasible.

Recruitment: the MDT considered and referred the patients.

Lawday and Compton (2013) implemented this second pilot project in 2009. Specific novel techniques were developed during the course of treatment, including the use of an agreed instrument as a 'safety call'. This was the free-standing cymbal. Each individual also made a

choice for their unique ‘sound print’ – a favourite instrument, a sound with which they particularly resonated. The G-CAMT research treatment manual was developed from this second pilot project

Procedure

The concepts of CAT reciprocal-role relating (Ryle and Kerr, 2002) were introduced gradually to the patients, who were all women on a gender-specific enhanced medium secure ward. The dialogical nature of reciprocation within jointly created music making was explained to the patients. This differs from analytical music therapy, in which patients are encouraged to freely associate within extended musical improvisation (Priestley, 1994). The creative process of making music was explained to the patients in a language that was reassuring and familiar. For example, if there were unpredictable sounds that the patients found frightening, they received encouragement that during the process of their gradual explorations a change could occur as it does when going from sucking a sour lemon to tasting home-made lemonade (Linehan, 1993). The purpose of the musical interactions was to promote emotional recognition through musical connectedness and communication with the salient verbal issues raised as part of the group process.

The group began with standard DBT mindfulness and breathing techniques. To these, the psychologist added grounding techniques, the purpose of which was to help to reduce dissociative responses if anxieties arose. The sessions began with the DBT skills of ‘observe’, ‘describe’ and ‘participate’, which were familiar to the women. There was no obligation to explore the instruments until each individual felt safe enough to do so. This was especially important in order for these patients to become comfortable with the instruments – as some were flooded with judgements about their own level of risk when exposed to new situations/objects. The idea was to gradually build up sensory awareness in a structured way, first through sound, then by adding visual aspects, touch and olfactory experiences.

Within the group process the psychologist commented on ‘skills’ as and when appropriate within the overall process of the therapy. For example in relating to musical sounds. The music therapist facilitated the group’s jointly created music and their reflections through the use of metaphor, and explored whether through observing mindfully, describing carefully and further exploring tentatively the sounds created, early efforts at jointly created music became easier and more comfortable. Through increased familiarity, and regular weekly attendance, the musical

interactions become richly enjoyable. Thus the music therapist observed and commented upon the use of DBT skills and concepts without making it the focus of the musical intervention.

The concern was that more than one sensory mechanism was being stimulated, which could lead to over-stimulation. The focus therefore moved towards distress tolerance. This involved the use of self-soothing, relaxation and grounding through breathing techniques by which to manage anxieties. The women used the sessions to observe and describe their emotional experiences. Some interpersonal effectiveness skills were also observed within and outside the sessions (e.g. asserting choice, paying attention to judgements, sharing, and building mastery and self-respect without hurting others).

For the first six sessions the psychologist who knew the patients took the lead, playing a protective role and yet looking to the music therapist for the musical lead and guidance. In this way, she herself became a bridge of rapport towards the music therapist, who was the newcomer and outsider. The psychologist was nevertheless able to express her own anxieties about playing musical instruments; as a positive role model, she displayed courage to explore and be vulnerable.

The music therapist and psychologist collaborated in order to integrate the two sets of therapeutic theories, techniques and modalities whilst keeping the experience for the patient as uncomplicated as possible. The main advantage for the patients was that they could try new experiences with some familiarity and that the intervention could be safely integrated with clear lines of feedback/communication to the clinical team. Patients reflected that they considered the two therapists to have different but complementary roles.

Generally speaking, a DBT group approach applies constraints on exploratory work in order to prioritise behavioural modification prior to individual exploration.

Results of pilot 2:

- Specific changes in relating were identified on the PROQ2 during treatment as opposed to during the control period.
- Statistical changes were evident across the mixed diagnoses of the participants compared with a non-participant, who was recruited but who chose not to engage.

- Changes in relating were confirmed in the PROQ2 domains of Lower Neutral (LN) Lower Distant (LD) & Neutral Close (NC) these will be explained in greater detail in chapter 5.
- These domains were identified as the four domains of PROQ2 to be measured for the main study.
- Both studies results confirm the need for an additional observational measure and more time points for measurement.

4.3.3. Discussion of pilot 2 and implications for future treatment

Lawday and Compton (2013) published the draft manual four years after the implementation; it was modified at a later date for use in the main study (5.1).

Relational changes on the PROQ2 outcome measure (Birtchnell and Evans, 2004) were compared with the number of incident reports involving these patients. The outcomes indicated that risks of harm were reduced during the treatment period for those who participated, with fewer incident reports for those engaged in the therapy than in the control period and in comparison with the results for the non-attender.

Following this pilot project, based on the findings, the MDT considered that the G-CAMT approach could be more explicitly staged into three phases of the overarching intervention: stages 5, 6 and 7:

5. Familiarity
6. Mindfulness
7. Distress tolerance

In the latter stages of the pilot project the patients were able to move on to the exploration of CAT reciprocal roles in interpersonal effectiveness, thereby incorporating interpersonal effectiveness skills where appropriate. It was hoped that ending would ameliorate past experiences of loss or fear of annihilation when times change. In the event, external events ruptured closure in a devastating way as one group member learnt of the death of a close family member on the day of the final session. The closure of the sessions and a natural period of reflection and appropriate mourning were not therefore possible. This real death had clouded the sense of achievement and closure for the three women who remained in the group, yet with such a short intervention period, follow-up sessions were not possible.

Qualitative feedback from one member included: ‘... growing in confidence. I have achieved my goal; I’d like to learn by just making sounds safely as there has been a lack of opportunity to do this. Sharing as a woman and knowing I was not alone has been helpful.’

In clinical practice, 12 sessions would be considered too short a treatment for such an extremely vulnerable client group to effectively build a rapport, accept a new intervention and therapist, and prepare for a resolved closure with natural sadness. Nevertheless, this final phase of intervention was evaluated as useful for those ready to move on to the ‘exploration and change’ stage of overall treatment.

Lawday and Compton (2013) describe how they experienced the negative impact of a purely psychodynamic approach on patients in an open group prior to the second pilot project for this study. They attempted to conduct a ‘taster’ session of music therapy in the ward environment of an enhanced medium secure unit, where nurses and patients had no prior experience of music therapy. One session demonstrated that this clearly was not a viable or effective way of working with these women owing to the lack of safe containment. Those women who participated in this open group became afraid of their own emerging feelings. The nursing team was left with the task of emotional regulation as these women dissociated. This was a shocking experience for the music therapist, who had to try to understand the new context of enhanced medium secure treatment and the wholly different patient response of the women to that of the men in the modelling group. The support of the lead psychologist in pilot 2 facilitated the music therapist and psychologist in going back to the drawing board with thinking space in which G-CAMT as a context-specific model was then carefully moulded to meet the needs of the patients in this treatment context.

The manual incorporates CAT tools and structures as well as specifically considering how to safely and creatively promote positive changes through jointly created improvisation, whilst taking into account the high risks of violent behaviour which are inherent in forensic treatment settings. The manual provides therapeutic techniques through which past and present experiences can be clearly separated. The purpose of this is to mitigate heightened responses, which could cause violent behaviours should past and present become inextricably associated. The aim is to increase the patient’s ability to self-reflect and think, thereby reducing the risk of impulsive actions. Novel techniques were incorporated in the form of the ‘safety call’ and the ‘sound print’.

4.3.4 Stages of the manual: developed from pilot 2 for the main study

Time-limited interventions are delivered within carefully staged multi-disciplinary treatment pathways for which the aims and objectives of individual treatment sit within an overarching treatment philosophy. The objective is to help the patient to move through the required treatments as smoothly as possible.

The research treatment manual prescribes four structured stages to the intervention. It was developed from the second pilot project, which was conducted on an enhanced medium secure unit for women in which the overarching treatment approach was DBT. Consideration had to be given to the four stages of Linehan's (1993) *Dialectical behavioural therapy (DBT) skills training manual* because the patients understood the four stages that she states as their overarching treatment approach. The challenge was in how these stages could be used to indicate compatibility, yet implemented with musical meanings, which are unique to G-CAMT.

Stage One G-CAMT sessions 1–4: Musical Mindfulness. The intervention starts by using limited musical resources which are not overwhelming. The instruments prescribed in the manual are specifically those, which arouse curiosity, using diatonic, rather than chromatic tuning, therefore ensuring harmony rather than dissonance. Patients are supported in observing, describing and safely familiarising themselves with the instruments and the therapeutic environment. Unique to this model is the concept of a 'sound print' (Compton Dickinson 2014 in press), which takes the form of an individual choice of instrument that may be used as a 'safety call' during group improvisation if an individual is feeling overwhelmed

Stage Two G-CAMT sessions 5–8: Emotional Recognition. The therapists have increased the musical resources with additional instruments. The focus is on further deepening the process of mindfulness by promoting emotional recognition through the jointly created music and in the verbal interactions between group members. This leads to the development of attuned relationships within the group and exploration towards how to resolve conflicts. Musical improvisations are carefully timed and structured to promote harmony and group cohesion. The music therapists have clinical autonomy in how the musical improvisations develop psychodynamically, yet they may choose to set a time limit for the playing of each improvisation.

Stage Three G-CAMT sessions 9–12: Distress Tolerance. At this point, as confidence and creativity have developed, more chromatic musical resources are introduced through which there is greater potential for musical dissonance and the accompanying engagement with feelings of discomfort which may arise from group discussion or improvisation. These may be resolved through the group process, which is facilitated by the music therapist. The expectation during the main study was that distress tolerance would lead to the next stage.

Stage Four G-CAMT sessions 13–16: Interpersonal Effectiveness. The final four sessions of the research study music therapy group were focused around creating a satisfactory feeling of closure and ‘farewell’. The ever-present awareness of time limit can activate distressing feelings and unconscious processes associated with prior annihilating traumas and associated deaths and endings. This may complicate the process of mourning as described by Roberts (2013) and Compton and Gahir (2013). This distress is frequently enacted within musical improvisation, during which the group may be unable to stop, or they may musically re-enact offence-related behaviours as described by Sleight (Sleight and Compton Dickinson, 2013).

At this point it is worth explaining that in the present study patients struggled to reflect on their past actions in which death had been inflicted by some of them, they had to address separation and unconscious death anxieties which arose in response to any sort of ending. The music therapists worked to contain the group’s fears musically, cognitively and verbally through joint activity, mapping and playing as described in the manual (Chapter 5). Patients realized they could survive a satisfactory farewell which was truly part of their treatment progress.

This closing stage was demanding on the music therapists, with containment of heightened group anxieties required, yet without denying the emerging feelings of sadness. The farewell letters, also part of a CAT approach, were prepared prior to the final sessions and shared within it. These are tangible artifacts of the group experience, which validated each individual patient’s progress and which served as an aide-memoire of the overall experience. These letters promoted insight into, and emotional engagement with, natural sadness at the ending of what was described by the patients as an enriching experience. The qualitative feedback from the therapists emphasises that the manual helped them to feel safe once they were familiar with it.

Further to this pilot project a more comprehensive working research treatment manual was developed. The manual as used in the present study is presented in chapter 5.

Chapter 5 The Research Study Treatment Manual: User Guidelines

Treatment Manual in Group Cognitive Analytic Music Therapy

By .Stella Compton Dickinson. With grateful thanks to co-therapists: Victoria Sleight, Music Therapist (Pilot 1) and □ Rebecca Lawday, Forensic Psychologist (Pilot 2)

Contents:

1. Introduction G-CAMT
2. Risk procedures
3. The patient group
4. Guidance for therapists: overview of the four stages of treatment
5. Principles of group therapy
6. Table of differences between G-CAMT and analytically informed music therapy
7. Assessment stage
8. Treatment sessions 1–4: Mindfulness
9. Treatment sessions 5–8: Emotional Regulation and Mindfulness
10. Treatment sessions 9–12: Distress Tolerance, Emotional Regulation and Mindfulness
11. Treatment sessions 13–16: Interpersonal Effectiveness, Distress Tolerance, Emotional Regulation and Mindfulness
12. Closure

NB. Numbering of sections has been modified to conform with the numbering of sections in the present thesis

5.1 Introduction

Group cognitive analytic music therapy (G-CAMT; Compton Dickinson, 2006) is an integrative, time-limited model of music psychotherapy. The treatment is designed for delivery to in-patients with primary diagnoses of schizophrenia or personality disorder, who are receiving treatment in secure hospital settings. The method combines the skills of the qualified music therapist with the tools and structures of cognitive analytic therapy (CAT; Ryle and Kerr, 2002). The CAT tools are easy to use and will be considered in clinical supervision. The jointly created musical component, which is non-verbal and emotionally related, is the active ingredient that is being tested for effectiveness and for which this manual has been written. It is vitally important to adhere to the manual so that the study tests the treatment rather than the therapists' skills.

The structured form of G-CAMT is designed to reduce risk by gradually helping patients to safely develop mindfulness techniques which promote greater awareness of the here and now. Emotional recognition is encouraged through increased abilities to self-reflect whilst making music. The group-work process is designed to improve distress tolerance and interpersonal effectiveness. These four aspects are used within dialectical behaviour therapy (DBT; Linehan, 1993). The techniques employed in G-CAMT are drawn from CAT and music therapy rather than from DBT. In this way, patients receiving treatment within the DBT philosophy do not have to learn a new language.

5.2 The Patient Group

5.2.1 Risk Procedures

Patients in secure hospital settings are in treatment because usually they have committed an offence, so they have a perpetrator state. Compliance with all hospital risk assessment and safety procedures is vital. This involves the development of good working relationships across disciplines. Liaison with the nursing staff will ensure that the music therapist can maintain a safe treatment setting. Nursing staff are involved in the referral process and may be involved in the therapy sessions.

5.2.2 Information about this Patient Group

Most offenders have a victim state which is usually rooted in negative childhood experience Wilde McCormack (2002 p161) explains that a self-state is defined through a way of being and feeling

which is distinct from other states and is only present for some of the time. Self –states vary and they require qualitative observation by the music therapist with a validating and non-judgmental description for each individual patient. The child state may typically be an abandoned, neglected, sad and/ or rejected child. The music therapist can work with the usual psychodynamic skills to consider what she is are feeling from the patient, then, based on the counter-transference experience, if and when the time feels right, the music therapist can ask or help the patient to describe his state, e.g. ‘I am wondering if you are feeling...?’

The music therapist can be aware of the patient’s transference responses and if signs of regressive child-like behavior occur, she can acknowledge this newly accessed ability, for example to be playful or tearful, without treating the patient as a child. Instead maintaining recognition of his adult state, and promoting his internal self-to self dialogue between the inner adult to child-states. Nevertheless, the music therapist can perceive whether the patient is eliciting a need to be mothered or if he is being seductive by acknowledging that everyone has an inner child state, which may need a reparative positive experience. She can consider whether and how it is appropriate to enact the reciprocal role polarities of mothering-to-mothered.

It is a joint responsibility between patient and therapist to maintain appropriate therapeutic boundaries. Part of the work is for the patient to get to know and be able to nurture his own inner child state. This may be helped through diagrammatic work in which the whole group can participate towards finding shared commonalities and their unique individual differences of experience and response. The music therapist can help the patient to feel playful, thereby redeeming lost aspects of his childhood in an adult way without him feeling too silly or demeaned. This process may also help him to think about how to be considerate to others without over-indulgence or over-stimulation. By promoting an ability to choose and share, each person may select their instruments for an improvisation, yet the patient may need the music therapist’s more experienced help to think about and choose without undue anxiety or impulsivity

Forensic patients are often very eager to please. This can be an over-compensatory state that can relieve feelings of guilt, by which the patient may be avoidant to address the issues that brought him to hospital. The therapists’ approach must be non-judgmental. Specific mention of the index offence is not made in this form of group work. Neither is index offences discussed during informal ward conversations, thereby a peaceful environment free of bullying can be maintained.

Index Offences are covered in individual therapy and psychology offence –based programmes. The associated emotions can however be worked on within the musical improvisations and through the use of metaphor. In this way difficult feelings can be reflected on with or without words. Offence related behaviours are visible as aggressive or intrusive responses within the group activity. The music therapist can facilitate the therapeutic working through of difficult experiences towards a process of restorative feelings of remorse rather than of guilt.

5.3 Guidance for Therapists

The Four Stages of Treatment: Key Words

5.3.1 Mindfulness: Present in the moment, supportive of reflective choice. Support each patient to reflect on various sounds to find a particular note or instrument that ‘feels’ right to him. This may, as the stages progress, become his unique ‘sound print’(p120). Use breathing and grounding techniques to support mind–body connection and to manage anxieties.

5.3.2 Emotional regulation: Encourage each individual’s to reflect on their own embodied feelings: ‘I feel like...’; ‘I feel as if...’; ‘Our/my music makes me feel like...’; or, ‘Our/my music reminds me of...’. Validate that each individual may have unique and different feelings about the same piece of music and about his own contribution to it. Make links between the expressive qualities of the music and each individual's internal state of feeling. Validate a sense of ownership of each individual’s internal subjective experiences. Consider if this can be made explicit verbally

5.3.3 Distress Tolerance: This stage introduces aspects of conflict resolution. In this stage each patient discovers how to tolerate differences of feeling and perception, thus at times group members may agree to differ when it comes to certain views or perceptions. This is a stage when verbal and musical dialogue may become more extended in the sharing-to-shared reciprocal role. Individual differences and group storming (Foulkes 1964) can be worked through in the group improvisations. The music therapist must provide sufficient safety and emotional containment to ensure that a satisfactory musical resolution is reached. At this stage, however, the aim is for each individual to discover that they can tolerate individual differences and survive feelings of frustration.

5.3.4 Interpersonal effectiveness: The final stage is about discovering a sense of harmony with others in more than just the musical sense. Individuals learn to negotiate choices, to respect each other’s distress and unique life experiences. The value of the group process becomes apparent as each individual prepares to end his treatment. There may be considerable distress and reactivation of perverse and potentially dangerous forces, because endings may be linked on the unconscious

level in the mind of an offender to a prior death, loss or offence. Closure of the treatment intervention is addressed in the CAT model, through addressing denial and anxiety. The absence of disappointment suggests an inability to mourn. (Ryle and Kerr 2002 p113) This may however occur non-verbally in G-CAMT within the musical expression and in each group member acknowledging their own and others contributions to the group. Each member and the music therapist may have the opportunity to reflect on how they choose to express feelings about ending in a closure letter. These can be read aloud in the final session.

5.4 Principles of Group Therapy

This section contains material from ACAT training delivered by Jane Blunden, 2008. Foulkes (1948), describes group analysis as a form of psychotherapy by the group, of the group, including its conductor'. Foulkes' basic law of group dynamics states that: 'the deepest reason why (group) patients can reinforce each others normal reactions and wear down and correct each other's neurotic reactions is that collectively they constitute the very norm, from which, individually, they deviate'.

There are four conditions that characterise 'wise crowds' (Surowiecki, 2004). They are: (1) diversity of opinion, (2) independence, (3) decentralisation (individuals are able to draw on specialised knowledge) and (4) aggregation (some way of turning private judgements into a collective decision). Surowiecki (ibid) states that if all four conditions are met, then group judgement is likely to be accurate. In aiming to achieve a cohesive group with good interpersonal effectiveness with severely ill offenders who have perverse mental functioning, this may be seen as an ideal rather than an ideally achievable objective.

There are similarities between Foulkes' basic law and CAT. Much of the theory behind group analysis is based in a deeply, fundamentally social paradigm. CAT is based on a radically social concept of the self (Ryle and Kerr, 2002). An individual's thoughts, feelings and behaviours make up his repertoire of reciprocal role procedures. These can be seen within group interactions and also as an outcome of an internalised group dynamic (Blunden, 2008).

All groups may go through the processes of forming, norming, storming, performing and mourning. This can happen in any order and therefore cannot be anticipated. The G-CAMT model, in keeping with CAT, follows Vygotsky's (1978) principle of learning socially from the more

experienced other. Ryle and Kerr (2002 p 41) explain that when learning in this way, the process of internalization involves prior stages in which skills are developed, along with concepts, which convey meaning. Therefore the aim of G-CAMT is to build interpersonal relating in a scaffolded way using the four stages of treatment that are outlined in the Manual. (5.1-5.8). The core activity in this creative process is that of jointly created music making, through which an emotional meaning in how individuals connect to form a group can be remembered and internalised. This non-verbal emotional connection can activate the process of abreaction which Freud and Breuer (1991) considered essential to effective treatment. The group dynamics are actively changing and evolving throughout the group-work process. The therapist therefore has the clinical autonomy to be assessing and working with whatever emerges, and this can be explored in supervision.

The forming stage of the group involves dynamic administration: looking after the setting, i.e. the room, equipment, time boundaries and ward communications (messages), and being thoughtful about how patients join and leave the group. Problems in groups may be: a quiet member; a talkative member who says too much; a member who acts as if he is the group leader; a member who deflects everything away from himself and on to other members; or a member who deflects everything on to himself.

The therapist has to dance between attending to individual needs and attending to the group as a whole. Scapegoating may occur, in which the group unconsciously selects a carrier member for its own badness, then sets about attacking or trying to expel that member. The group may become stuck, in which case a useful question to ask either to oneself or to the group is, ‘What is not being said?’ or, ‘What is missing?’ If there is a frequent absentee, is that member taking something outside the group on behalf of the whole group?

All groups offer members the chance to see themselves as others see them –thus a member may become aware of an aspect of himself through another’s reaction. This could be helpful or at other times very painful and unnerving. In G-CAMT, consider whether it is helpful and positive to name something, but do not make a psychoanalytic interpretation. The latter may be perceived as frightening and exposing in that the therapist mysteriously knows something that is not yet conscious to the individual. Instead, the technique to use is to name and work cognitively and creatively in a collaborative manner.

G-CAMT clinical supervision will be provided as weekly group supervision, which incorporates CAT principles and guidance, as well as the music therapy process. ‘Group supervision, like group analysis is a form of psychotherapy supervision by the group, of the group, including its supervisor’ Group supervision will consider the parallel processes that occur between the group therapy and the supervision group.

Table 5.1 was written as a scientific exercise prior to the pilot project. The purpose was to provide evidence for a novel approach to meet the needs of the forensic population and of music therapists working with the risk of violence. Furthermore, this table shows techniques and modifications to manage the risks of violence, validating the need for a context specific prototype music therapy research treatment manual. This manual was subsequently revised for the present study following the pilot project. (4.2. 4.3) Following the implementation of the present study it became apparent from patient presentation that stages 3 and 4 of the manual manifested in reverse order. This phenomenon is discussed in chapter 10. (10.5.1) This table shows how G-CAMT has been tailored for the forensic population and how it differs from psychoanalytically informed music therapy.

Table 5.1: G-CAMT tailored for the forensic population for Pilot 2.

Active ingredients	G-CAMT process	Psychoanalytically informed group music therapy
<u>Stage 1. Mindfulness techniques</u>	<ul style="list-style-type: none"> • ‘Observe, describe, experiment’ to introduce musical instruments gradually • Grounding techniques 	<ul style="list-style-type: none"> • Free association, - focuses on unconscious processes
Level of joint activity	<ul style="list-style-type: none"> • Dialogical, structured and contained joint activity 	<ul style="list-style-type: none"> • Narrative: often extended
<u>Stage 2. Emotional regulation through jointly created music making</u>	<p>Encouragement of a verbal and musical exchange in the form of a listening dialogue</p> <ul style="list-style-type: none"> • Turn taking is encouraged to develop reciprocal relating 	<ul style="list-style-type: none"> • Potential offence-related behaviours re-enacted in extended improvisation <p>Potential for emotional</p>

	<ul style="list-style-type: none"> • Toleration of silence monitored and contained • Duration of emotionally attuned musical interaction is monitored and guided • Therapist stance: active, receptive and observational 	<p>flooding through over-extended musical expression</p> <p>Therapist stance: passive, receptive, analytical using verbal interpretation</p>
Psychodynamic processes	<ul style="list-style-type: none"> • Aimed to elicit non-judgemental social relating and safe attachment in thoughtful creative self-expression with positive role modelling from the therapist 	<ul style="list-style-type: none"> • Initial negative transference elicited through the neutrality of therapist's stance. This can increase frustration, feelings of shame and risks of disengagement and harm to self and others
<u>Stage 3. Interpersonal effectiveness</u>	<ul style="list-style-type: none"> • Use of visual prompts, eye contact, physical movement and the naming of issues to develop self-reflection 	<ul style="list-style-type: none"> • Use of interpretation and possibly no eye contact
Interpersonal relatedness	<ul style="list-style-type: none"> • Use of verbal prompts and musical techniques: listen, wait, respond, and take turns. Call and response 	<ul style="list-style-type: none"> • Uninterrupted extended narrative in storytelling
<u>Stage 4. Distress Tolerance</u> Issues of Loss	<ul style="list-style-type: none"> • Creative self-expression is gradually extended as new ways of relating 'exits' are discovered and replace destructive or distressing relating procedures • Preparation for closure and acceptance of loss in a focused way using closure letters, cognitive mapping 	<ul style="list-style-type: none"> • Analytic group-work models in pure form can increase anxiety to intolerable levels through long silences and the re-emerging of primitive unconscious conflict enactments and unrecognised violent endings. The group facilitator allows for

	<p>and emotional relatedness and the expression of sad or angry feelings in music to work through the mourning process</p> <ul style="list-style-type: none"> • Conflict resolution techniques through therapists' meditation and a non-judgemental approach. 	<p>working through in a mourning process</p>
<p>Scaffolding = Learning non-didactically from the more experienced other (Vygotsky, 1978).</p>	<ul style="list-style-type: none"> • Stability of time and place • The making of artifacts in the form of diagrams and therapy tools and artwork • Recording of jointly made music to build self-esteem and positive self-appraisal of creative potential • CAT tools: psychotherapy file. Sequential relating diagrams are formulated 	<ul style="list-style-type: none"> • Stability of time and place. Listening back to chaotic, disturbed improvised music can sometimes be too shocking for patients, thus reopening the narcissistic wound
<p>Interpersonal effectiveness</p>	<ul style="list-style-type: none"> • Group processes in reciprocal-role relating, e.g. caring-to-cared for. Diagrammatic work aids recognition of individual reciprocal roles as they emerge in the group process. Use of closure letters resolves the closure of treatment 	<ul style="list-style-type: none"> • Achievement of the Kleinian depressive position as a resolution of mourning
<p>Psychodynamic Processes</p>	<ul style="list-style-type: none"> • Senior therapists can use Counter-transference and Transference processes: to feed back and facilitate new, 	

	more effective relating experiences	
Duration	<ul style="list-style-type: none"> • Time-limited closed groups utilise closure letters and address fears of endings and death (both metaphorical and real) 	<ul style="list-style-type: none"> • Slow open groups do not have a pre-agreed closure point. The meaning of endings is addressed as members move on from time to time rather than there being a whole-group closure
Use of Instruments	<ul style="list-style-type: none"> • Emotional attunement and the ability to be playful in creative ways can develop in rewarding short improvisations that promote group unity and a sense of achievement • Carefully selected small supplies of instruments are gradually increased. Larger instruments can be perceived as more threatening, or in contrast may help a patient to feel safe. The emotional effect should be carefully explored 	<ul style="list-style-type: none"> • Potential to be threatening and overwhelming if not moderated with this violent offender client group • Free choice

5.5 Individual Assessments and Treatment Sessions 1–4: Mindfulness

This stage begins with two individual assessment sessions followed by the first four group-work sessions. The following section provides an explanation and guidance for music therapists.

5.5.1 Purpose of the Sessions:

- The music therapist will use her relational sensitivity and abilities to establish a positive

therapeutic rapport and a sense of safety thereby putting the patient at ease.

- To assess the patient's relational abilities and in building the therapeutic alliance reassure him that he can choose whether or not, and when to actively engage with musical instruments.
- Attention to one sensory experience at a time will build up recognition of each sensory modality. The visual impression, touch, sound and even the smell of musical instruments can promote active musical engagement with a specific musical instrument.
- Introduce instruments very gradually: less is more. In this way, ensure the patient is not overwhelmed or intimidated by the sight of too many unfamiliar instruments. This could be threatening to his sense of security or increase fears of what is expected of him.
- To explain the purpose of therapy: during the assessment sessions the therapist and patient together will look at and complete relevant parts of the psychotherapy file and the out the sounding bowl may be introduced. The qualities of this instrument have been central in the development of CAMT and its use is recommended wherever possible. Sounding bowls are made by one sole maker, Tobias Kaye <http://www.soundingbowls.com/>.
- Consider with the patient what he would like to achieve by participating in this group. Write this down for each individual as a target aim. For example: 'I want to be able to share my feelings with others'; and as a target problem: 'I don't know how to express my inner feelings'; or 'I don't know how to get in touch with my feelings and hope that making music with others will help me to do so.' Each patient keeps a copy.
- To assess the patient's ability to converse in dialogue explaining the nature of the collaborative, therapeutic relationship in which the patient's views and choices are central towards a shared understanding in listening and developing this dialogue.

5.5.2 Content and Structure of Sessions:

- Work with a carefully selected, limited choice of instruments. Reassure that there is no obligation to touch or play the instruments.
- Assess whether the patient may feel overwhelmed by sensory input or anxious about fear of exposure.
- Give plenty of reflective space but observe and monitor anxiety levels and be prepared to sensitively break the silence if it becomes too uncomfortable. The therapist's task is to encourage ongoing engagement and positive feelings rather than fear.
- Encourage observation and description of instruments.
- The therapist may 'role model' by observing and describing the process.

- Encourage active dialogue; if necessary, be prepared to prompt rather than allow an extended narrative to develop from one patient. Always give unconditional regard.

5.5.3 Musical instruments to use:

- Tibetan singing bowl and/or Tibetan chimes.
- Djembe drum for turn taking and the encouragement of dialogue and a direct connection through the hands to the drum. Do not use beaters.
- Introduce patients to the sounding bowl, working carefully with the different sensory fields. Build these up gradually one by one: visual (what does it look like); tactile (what does it feel like?); vibrational and auditory (what does it feel and sound like?).

5.5.4 CAT Tool to use:

- The Psychotherapy File.

This should have been introduced during the first session at a point that felt right. For example, look together at different states and self-states. Based on patient verbal content and written responses on the file, decide which other parts of the psychotherapy file are most relevant: Traps, Snags or Dilemmas.

5.5.5 Homework Task:

- Ask the patient to think about what they would like to achieve during a short piece of group music therapy.
- Formulate the target problem.
- Consider this in supervision.

5.6 Treatment Sessions 5–8: Emotional Regulation and Mindfulness

5.6.1 Purpose of Sessions:

- To encourage patients to engage with their feelings within the group's music and on a personal level.

5.6.2 Content and Structure of Session:

- Work with carefully planned and timed short improvisations that come out of the verbal

dialogue.

- Base the improvisations on the verbal themes in the 'here and now', or if the group express that they feel stuck, begin with improvisation from which verbal issues may emerge.
- Ensure that the music is harmonious and feels 'nourishing' rather than chaotic; for example, use a predictable ground bass (Wigram, 2004) or motif consisting of from three to five notes. This may be repeated in different octaves or with different spacing, but it should have an emotionally containing effect, which serves the purpose of a signpost to which group members can respond. However, if any individual is clearly disturbed, this may be reflected within chromatic or diatonic dissonance (major or minor seconds). The feel of this must then be woven into the overall texture of the improvisation with the therapist containing and supporting the disturbed patient within the musical context. This can validate the patient's inner experience and facilitate a sense of inclusion. Ensure that other group members can remain fairly cohesive whilst those who are struggling are helped to integrate.

5.6.3 Musical Instruments to use:

- Bass chime for grounding and calming.
- Power chimes for resonance.
- Small hand-held percussion for tactile and auditory effect, e.g. cabasha, guiro, African and Latin shakers and rattles.
- Djembe drums: call and response drumming between two subgroups.
- The therapist may choose to play baritone metallophone, bass xylophone or pentatonic xylophone. Basically, any such instrument that provides sufficient melodic range as well as grounding, calming harmony. Consider whether use of keyboard or piano may break the cohesiveness of the group circle. If so, this should not be used at this stage.
- Encourage exploration and choice with supportive prompting to think about whether the sound of an instrument 'feels right' for the individual and for the group's overall mood.
- Each individual should by now have discovered a favourite instrument, the sound of which can become recognised within the group as that person's 'sound print' (Compton Dickinson, unpublished). The sound print is a specific resonance unique to each individual. The music therapist can encourage reflection on the meaning and emotional purpose of this instrument as a place of safety to which the individual can return at any time within making music. This can also act as a warning sign that the individual may be feeling unsafe and in need of group or therapist support.

5.6.4 CAT Tool to use:

- Continue to use the psychotherapy file
- Help the group to think about and share their Traps, Snags and Dilemmas. Identify which ones they have in common. Name these and encourage collaboration and sharing.
- Introduce the concept of reciprocal roles in musical and verbal dialogue in reference to patient content and presentation. Draw a diagram of controlling-to-controlled, self-to-self, self-to-other, other-to-self.
- Start to formulate a diagram in supervision.

5.6.5 Therapeutic aim and Technique:

- Recognition of each patient's own reciprocal-role procedures as enacted within the group, e.g. controlling-to-controlled.
- Recognition of target problem procedure through verbal reformulation.

5.6.6 Homework Task:

- Journal keeping: things that have happened during the week, dreams, issues to bring to the group.
- Self-reflection on the target problem and noting when repeating the target problem procedure with peer interactions.
- Consider in supervision.

FOLLOWING THIS STAGE THERE IS A MID-TREATMENT BREAK FOR ONE WEEK

5.7 Treatment Sessions 9–12: Distress Tolerance, Emotional Regulation and Mindfulness

Stage 3: Distress Tolerance

5.7.1 Purpose of Sessions:

Tolerating disharmony and learning from the more experienced other.

The therapist must be able to role model how to address conflicts within the group and in the wider hospital context. For example, how therapist and co-therapist negotiate and hold the group rules and boundaries. A typical example may be if a patient has a planned visitor coming to the

ward, the time of which clashes with the group session. The therapist can support the patient firstly by helping him to think how he may be able to talk to nursing staff to ensure that he sees his visitor without disruption to his treatment programme. The therapist, by talking with the patient and encouraging group involvement, must assess whether it is appropriate to provide direct help or whether that patient can manage to negotiate the situation himself.

5.7.2 Content and Structure of Session:

- Widen the range of emotional expression to include creative expression of frustration and anger. This may, for example, relate to inevitable feelings linked to the controlling-to-controlled reciprocal role which is common in the early relating procedures of many people who become offenders, as well as in the necessary containment provided in secure hospital settings.
- Encourage a wider range of dynamics and explore whether loud sounds are frightening. Encourage reflection on whether a sound is expressive of an emotion or just a noise.
- Facilitate a drumming circle and freer rhythmic work.
- Introduce consideration of the use of beaters on percussion and the difference between using direct contact with the hands and the potentially more violent and potentially less personal effect of the beaters. Question whether beauty of sound can be both appropriate and achievable.
- Develop more energetic, cathartic input for expression of anger and release of negativity.

5.7.3 Musical instruments to use:

- Include larger instruments such as temple blocks, keyboards.

5.7.4 CAT Tool to use:

- State Characterisation Procedure (SCP) (Ryle, 2007a)

5.7.5 Therapeutic aim and Technique:

- Observe very carefully whether patients move between different self-states, for example, from an overwhelmed victim state to an aggressive and attacking state, or a blanked off 'zombie' state, or just a state of soldiering on.
- Be aware that patients may form into pairs, which can be detrimental to the overall group process and must therefore be addressed.

5.7.6 Homework Task:

- Recall an issue of disagreement. Bring this to the next session.
- Record a positive interaction with staff or peers, in particular describing how this has been addressed using a new CAT 'exit', with the patient's recognition of his own reciprocal roles.

5.8. Treatment Sessions 13–16: Interpersonal Effectiveness, Distress Tolerance, Emotional Regulation and Mindfulness

Stage 4: Interpersonal Effectiveness

5.8.1 Purpose of Sessions:

- To experience group cohesiveness in addressing relevant interpersonal issues.
- Managing separation anxiety and preparing for closure.

5.8.2 Content and Structure of Session:

- Extended emotionally related improvisations with consideration of how to begin together and how to resolve the ending of each piece. The symbolic effect is subtly to ensure that each patient is experiencing a negotiated beginning from agreed silence and a 'good enough' ending in harmony.

5.8.3 Musical Instruments to use:

- Use a full range unless patients begin to enact destructive impulses that represent offence re-enactments.
- Consider whether the use of the keyboard or piano is positive or whether it breaks the cohesiveness by breaking the circle.

5.8.4 CAT Tool to use:

- Group diagram

What do we each bring to the group?

What will we each take away from the group?

5.8.5 Therapeutic aim and Technique:

- Preparation for closure and new beginnings.
- Address separation anxieties and encourage mourning within jointly created music.
- In supervision and observation, reflect on potential parallel processes by which the patient is indirectly expressing his concerns. This can impact on multi-disciplinary cohesion, and it is vital that the music therapist is able to explain and contain and ask for MDT support to help the patients through this difficult and vital process of 'good enough' separation from the attachments formed within the group.

5.8.6 Homework Task

- Preparation of closure letter. Each individual will read out his own letter to the group within which he will reflect on the role of each of his peers and the impact on himself of the overall experience. He will consider his aspirations, his disappointments and whether he has successfully addressed his target problem.

5.8.7 Final Session: Closure

The date of the final session will have been known about from the beginning of the treatment intervention, due to the pre-agreed time –limit of 16 sessions. Each session number is named and noted on a weekly basis, by both therapists and patients. Inevitably, with only 16 sessions, this ending process may not amount to a full sense of resolution. Past losses may surface implicitly as the meaning of being part of a cohesive group may reactivate sad memories or bring up wistful feelings. Sadness can be felt, acknowledged and expressed within the music.

A follow-up session will be planned for 8 weeks' hence. This enables a settling in period during which the therapy process can be reflected on and internalised by each participant. The reunion of the group for one session can help to keep the target aim in the patient's consciousness and can create a safe space and time for each individual to consider what he has learnt with others and how things may or may not have changed in his treatment pathway.

Copyright of the Author: Stella Compton Dickinson 19/01/2010

Edited by Odell-Miller, H. 22/01/2010, Compton Dickinson, S.J. 29/01/2010

Chapter 6 Rationale for the Methodology of the Main Study

In this chapter, (6.1) describes the rationale for the methodology of the main study, first with reference to theories of attachment that are relevant to the design and to the treatment context. These are demonstrated through existing literature, and with clinical vignettes. (6.2) describes the rationale for the treatment manual and for the method, and how this was modified to be feasible for the implementation of an ethically approved study in the high-secure setting. The case is then made for the selected sampling procedure and the selected outcome measures. (6.3) states the central research question with objectives. (6.4) lists the experimental hypotheses, which are tabulated with the selected outcome measures. In (6.5), the method of implementation and in (6.6) the ethical considerations are describe. (6.7) discusses the sample characteristics. Then (6.8) gives details of the inclusion and exclusion criteria. (6.9) states the power calculations to determine the sample size. (6.10) then describes the sampling strategies with reference to the consort diagram and final patient allocation. (6.11) describes in greater detail all the assessment instruments, starting with a description of the primary outcome measure with explanatory diagrams of the positive and negative attributes that are described in the eight domains. (6.12) describes the procedure for recruitment. This is followed by (6.13), which discusses the procedures for data collection. Finally, (6.14) presents the methods of analysis.

6.1 Rationale for this study

In secure hospitals in the United Kingdom, a multi-disciplinary approach involves the delivery of concurrent treatments tailored to each individual's needs. Yet, these time-limited interventions are programmed within structured multi-disciplinary treatment pathways.

McMurran (2009) conducted a review of research strategy in the forensic services of one NHS Trust. McMurran (ibid) found that research was well developed in male personality disorder high-secure hospital services, but that more was required for patients with a primary diagnosis of severe mental illness. A form of music therapy is required which is compatible with offence-related, cognitive, psychosocial, educational, and occupational therapeutic treatment programmes within the pathway el, without the need for additional training.

The process of building sufficient evidence on which to validate a mixed-methods randomised controlled, patient preference trial for the treatment of patients who have offended and who are

receiving treatment in a secure hospital began, as described in chapter 4, with a series of single cases of time-limited CAMT, which were evaluated pre and post treatment. These are cited in the National Institute of Clinical Excellence (NICE) Scoping document (2003). This was followed by the two-year modeling stage (Sleight & Compton 2013), and then the time-limited pilot project was implemented (Lawday & Compton 2013). The research treatment manual for the main study (5.1) was developed from the treatment protocol of the pilot project.

People who have committed serious offences have diverse treatment needs. In the absence of rigorous clinical evidence in this area, Tapp et al. (2011) highlighted the need for the inpatient perspective. They cited the Department of Health (2001), who stated that the patient perspective is notably under-represented in the high-secure hospital population. Drawing from the pragmatic evidence of Blackburn (2004), Quinsey (1988), and Rice and Harris (1997), Tapp et al. (ibid) explained that the focus is otherwise only on outcomes and public interest, which is that of recidivism. Tapp et al. (ibid), therefore, conducted a thematic analysis of data drawn from 12 patients in a high-secure treatment who were considered ready for discharge. The analysis revealed eight themes, which the patients themselves considered to have been helpful. These eight themes included temporary suspension of responsibility, collaboration in care, learning from others, supportive alliances, specific interventions, medical and psychotherapeutic, a safe environment, and opportunities for work. Tapp et al. (ibid) cited Malterud (2001) and Yardley and Marks (2004), who demonstrated that a qualitative research approach could provide a complimentary view by triangulating patient experiences with evidence from other stakeholders.

Craig et al. (2008) and Whitley and Crawford (2005) stated that the inpatient perspective is of particular interest in discovering what works in the context of an overall therapeutic approach in which there are multiple therapeutic ingredients. Formal interventions may operate either independently or together toward the overall goals of rehabilitation. These goals involve working with relational security through the development of supportive interpersonal relationships, as well as the hospital security procedures. Both are developed with the intention of keeping patients, staff, and the general public safe from harm, yet both of these areas of security are vulnerable to abuse. The abuse of these boundaries requires consideration in developing a form of therapeutic intervention that can be safely used by music therapists who may have no prior knowledge of the secure hospital setting, nor experience of working with people who have committed serious offences. The abusing to abused reciprocal role is an overarching concept, which may include bullying to bullied tactics in the workplace. This role

can be perceived by staff or patients in many subsidiary and harmful forms, for example: as persecuting to persecuted, humiliating to humiliated, or shaming to shamed.

These roles can operate in parallel levels at many levels within an organizational and managerial hierarchy. If professional relationships become toxic due to envious attacks erupt which are left unprocessed. Alternatively, through projections received from a patient who has killed. Wilde McCormack (2002 p105) describes how many murders are committed by people who have spent their whole lives caring for others, and who were unable to say 'no' to their tyrannical charges until they are pushed too far, having harboured resentment which explodes in the dilemma of either feeling lonely and empty and unwanted or the busy carer. Thus, it can be seen that patients and staff can suffer from the same challenging feelings in maintaining a place of assertiveness rather than being caught in the trap of always trying to please.

6.1.1 Attachment and therapeutic engagement

Adshead (2002) highlighted the need for supportive interpersonal relationships, both in the communal ward setting and in formal therapy. There are, however, inherent dangers in the process of building therapeutic alliances. Peternelj-Taylor (2012) stated that sexual boundary violations in forensic mental health settings should be considered as an occupational hazard, rather than simply as a social and professional taboo. Aiyegbusi (2012) conducted a mixed-methods study into boundary violations between nurses and patients in high-secure and enhanced medium-secure hospital settings. Aiyegbusi (ibid) explained the nurse-patient relationship as a phased interpersonal process that is developed through the nurse's use of the self during interactions and communications. The patient must feel 'held' enough to develop an attachment effect through which they can engage in a process of interpersonal change.

Aiyegbusi (ibid) interviewed 10 nurses and conducted patient focus groups, which enabled the voices of nurses and patients who are rarely heard to provide information for areas of further study. The qualitative data analysis of this study revealed themes in five key areas, including knowledge and understanding of boundaried relationships, applying boundaries in clinical practice, the therapeutic milieu and structured routine, complex interpersonal relationship work, and self-awareness.

These key areas are equally significant to music therapists in understanding the impact of their absence on patients and the risk of acting out the projections of a patient due to the emotional impact of the therapeutic work. Aiyegbusi (ibid) concluded that whilst patients may not wish to abuse a relationship again, or to be abused, they need support from nurses, as well as other clinical professionals, and that a crucial part of that support involves all parties being able to withstand tremendous pressures which have the power to corrupt the therapeutic relationship.

6.1.2 Mindfulness, emotional regulation, and conflict resolution in music therapy

Music therapy is one of the most intimately interactive of the arts therapies because therapist and patient are actively involved in the creative process of making music. An understanding of the abusing-to-abused reciprocal roles that may emerge helps to reduce the risks that are inherent in these levels of interactive connection and which hold a risk of over involvement through the development of feelings of intimacy.

The psychodynamic skills of the music therapist are utilized whilst engaged in jointly-created improvised music. The music therapist responds musically to the perceived moods of the patients as experienced through the counter-transference. Attention is paid to the meaning of all non-verbal communications and behaviours, as well as their congruence to verbal input. The musical interaction is a form of emotionally-based non-verbal relating, which is intended to create a bridge that can link feelings to words.

Sleight and Compton (2013) described the positive effects of this phenomenon (4.3.2), as the two music therapists improvised together as a prelude to running their group. Their intention was to connect mindfully with each other and to hold on to the joy of non-verbal connecting in a sharing-to-shared reciprocal role. Musicians per se are mindful of this effect, which has life-long positive and lasting effects in their lives, since they played together in a meaningful way. As a result they continue to feel connected long beyond their years of actual contact and frequently can pick up the relationship where it left off from many years ago.

Memories and anecdotes are often shared of past musical experiences together, because the level of connection was both meaningful and internalized. This inner meaning of jointly- created music may link to the aesthetic qualities of the music. Lee (2000) considered the developmental aspects to the client of the aesthetic qualities of musical improvisation. Lee (ibid) developed techniques for the microanalysis of the improvisations through which he considered his own

feelings and the levels of intimacy within the therapeutic relationship. In this way, Lee could also gain greater understanding of his client. Lee's (ibid) work highlighted the value of self-reflection and mindfulness, not only of the patient, but also of the music therapist, both during and after the creative process.

Aigen (2013) considered the process of making music from the perspective of how jazz musicians relate to one another when improvising; he explored how this relates to music therapy and how people relate to each other during the process. Aigen (ibid) explored the similarities between the two, in terms of spontaneity, creativity, responsiveness in the moment during improvisation, and the process of making music rather than the finished product.

Aigen (2005) also acknowledged the value of theories in music-centred music therapy from various perspectives, including ethnomusicology, sociology, and psychology. Aigen (ibid) highlighted the importance of the sociocultural context in which music is made and how this facilitates an understanding of the music and of people.

The opposite may also, therefore, be true of how the process of making music may provide understanding of the context itself. The musical process may become abusive in a toxic clinical situation, which is at times permeated by violent thoughts or perverse thinking patterns. Therefore, the context and the ways in which the people within that context create their own music, can throw light on the inherent problems, psychodynamics, and people who are encountered in institutional life.

Compton Dickinson and Gahir (2013) later described this phenomenon in working with the parallel processes of conflict at the level of the patient, the MDT, and societal levels. This phenomenon is also demonstrated in forensic music therapy by Santos (2001), Glynn (2002), Cormac and Hughes (2013), Roberts (2013), and Sleight and Compton (2013). Thus, music therapy may bring a new perspective to the MDT discussions with regard to patient behaviour, risks therein, and future treatment planning.

McGauley and Humphrey (2003), Riordan (2008), and Sarkar (2005) described the high-secure hospital patient group and the links between disrupted attachments, trauma, offending, and the parallel processes that can occur within the MDTs. Annesley and Jones (2013) highlighted this phenomenon by citing an example from Compton Dickinson (2006), in which a psychopathic man intentionally tuned his guitar to be out of tune, thereby creating distance from the music

therapist. This demonstrated that therapeutic engagement, real relating at an intimate level and emotional connection in individual music therapy, is challenging to a patient whose trust in others is damaged through traumatised childhood relational attachments. Therefore, sensitive consideration of how this patient group relates and whether they can engage therapeutically is viewed as a relevant area for further enquiry.

Bennett, Parry, and Ryle (2006) addressed this aspect in CAT, in which they developed a methodology to resolve threats to the therapeutic alliance. A predominantly positive therapeutic relationship typifies time-limited CAT. This is a significant and fundamental difference from psychoanalytic music therapy, in which a negative transference may be elicited at an early stage. The latter poses a significant threat to ongoing therapeutic engagement with patients who have offended in a secure treatment setting. Bennett et al. (ibid) cited Martin, Garske, and Davis (2000), who stated that the most consistent predictor of outcome in psychotherapy is the quality of the therapeutic relationship; this aspect is fundamental to this study, in which the dependent variable is that of how people relate to others. For patients who have had traumatic and abusive childhoods, relating in an authentic manner is a challenge, since they have developed so many psychological defences in order to cope with unpredictability. Thus, if the re-activation of memories occurs too early in therapy, through too much life review too soon, this can both re-traumatise the patients and contribute to offence-related behaviours.

Sleight and Compton (2013), in their publication of the modeling stage of this study, which was conducted in 2009, demonstrated how violence and conflict resolution is represented in musical interaction in the group process. Sleight and Compton (ibid) described how offence re-enactments could be made visible and conscious through unconscious musical responses in the 'group wars' that ensued when one member felt compelled to destroy the group. This occurred when 'Craig', responding to his unconscious emotion of exclusion, his reciprocal role of being the excluded one was re-activated and with it, his archaic feelings of victimization arose. The reciprocal role procedure (RRP) developed as Craig responded to this sense of being overwhelmed, by enacting an overwhelming reciprocal role by attempting to corner and victimize one of the music therapists when she was in a vulnerable situation. This directly reflected the disharmony that Craig had felt for his original family situation, which had been expressed in the musical argument, which ensued. Sleight and Compton (ibid) described the therapeutic techniques, which they used to enable 'Craig' to stop this impulsive drive toward destruction within the group's musical improvisation. These techniques were subsequently

incorporated into the manual. In this way, Craig was able to reflect on his past violence and, eventually, to speak for the whole group in saying that he was 'sad' as the closure approached. The process facilitated Craig's ability to begin to think about his index offence, and to feel remorse about the tragedy and sadness of the annihilating act that he had committed earlier in his life.

This example highlights the risks that can be witnessed in jointly-created music if an uncontrollable flooding of emotion occurs. The skill of the music therapist lies in supporting the patient to access and express enough, but not too much, emotion through jointly-created music (Compton Dickinson, 2006). The outcome in the above case would have been different if Craig had not been sufficiently contained and supported by the group process. If a patient is left with an unprocessed re-traumatisation effect linked to childhood victimisation, this will inevitably impact his behaviour outside the group and, thus, affect his peers and the nursing team. It is this aspect in forensic psychiatry that can frighten other clinicians in terms of the effect of the less structured form of psychodynamic music therapy.

In this example, Craig had been provided with some cognitive understanding and non-judgmental support within the group. This helped him to think consciously about his responses and his newly-recognized, but uncomfortable, negative feelings. His response was to fight in the symbolic form of vengefully threatening the music therapist through initiating a ritualistic beat on the claves, with which the other men joined in. This sort of enactment is termed an offence-parallel behaviour (Jones, 2008), in which the music therapist may not be able to stop the more primitive impulses of the group as a whole. Thus, a novel 'stop' technique has been incorporated into the manual.

The manual employs mindfulness techniques, as well as cognitive, behavioural, and relational aspects of guidance for music therapists. Nevertheless, this model enables the music therapist to have clinical autonomy in how the musical improvisations develop, so that they can continue to use their psychodynamic training and skills.

The aim of G-CAMT is to encourage patients to engage with their issues non-verbally by employing clinically effective, safe, musical and psychological techniques in which patients can express themselves non-verbally, whilst focusing on relevant events, which previously may have been unspeakable, as well as developing a cognitive understanding of their problems.

As a general rule, music therapists are not trained in CAT. The music therapists in the present study received weekly group supervision in the CAT model with the Principal Investigator (PI) in a similar manner to which she had done whilst on the CAT training model at St. Thomas' Hospital, London. In this way, the PI was involved in the qualitative aspects of the methodology, and her supervision was super-supervised by her supervisor to ensure treatment adherence to the model, whilst the music therapists were able to learn about and comply with the CAT model

Prior to the development of the proposal for this main study, supportive evidence was disseminated at the site from the systematic reviews by Gold, Hedál, and Wigram (2005), and a community-based RCT for people suffering with schizophrenia (Talwar et al., 2006). At this stage of the development of the research project, the developmental, modeling, and piloting stages of G-CAMT at the research site had been stimulated through attendance and presentations at the following professional meetings: the World Congress of Music Therapy in Oxford (2002), Brisbane, Australia (2005), Buenos Aires, Argentina (2008); the Canadian Association of Music Therapy, Perth, Ontario (2004); and the European Music Therapy Confederation, Eindhoven (2007), and Cadiz, Spain (2010). Knowledge and experience specific to forensic psychotherapy and to the treatment context were gained from attending professional seminars and conferences, as well as presentations of music therapy developments at the annual conferences of the International Association of Forensic Psychotherapy in Oxford, UK (2006 and 2007), Venice, Italy (2008), and Konstanz, Germany (2009). Further understanding and to keep in touch with CAT group work developments and research was gained by attending and presenting at the Association of Cognitive Analytic Therapy annual conference (2009) and the International Cognitive Analytic Therapy Association, Krakow, Poland (2011).

6.2 Methodology of the Main Study

Creswell (2003) describes a pragmatic design that links methods to outcomes and examines which strategies of enquiry will inform the procedures towards developing a framework for research design. A pragmatic design as applied to mixed methods research is not committed to any one system of philosophy, therefore qualitative and quantitative assumptions could be applied, therefore a patient preference model of randomisation (Torgeson, 1998) was selected as feasible in the context of a high secure hospital. The principal investigator and the music therapists were masked to the randomization process, which was conducted independently by the senior evaluation officer. Partial randomization was possible as follows: (a) patients who

had no strong preference to either treatment or control consented to randomisation; (b) patients with a preference for either treatment or control but who still consented to randomisation; and (c) patients who chose their preference for either the treatment arm or the control arm of the study and therefore refused randomisation. Randomisation to the treatment sample was subject to the participant's availability based on each individual's MDT treatment timetable and availability. (Nice Guidance 2010) All participants had an initial individual session on their ward in preparation of the music therapy group treatment intervention. This methodology was pragmatic in that retention to the study was feasible within a MDT approach and in accordance with the NICE guidance (2010). Four participants were lost to attrition thereby undermining the power of the study design. A further framework of design was required in which mixed methods with qualitative enquiry could be compared with the statistical results. This is a problem centered, real -world oriented approach that is unlike a purely postpositive reductionist approach.

Stirman et al. (2005), Morrison, Bradley, and Western (2003), and Slade and Priebe (2001) argued that by proposing an RCT in psychotherapy, the problem remains in how to yield sufficiently reliable or valid findings, due to variations in the components of standard multi-disciplinary care in the study population.

Variables in standard care in the study population include specific offence-related psychology treatment programmes recreational music-as-listening groups, and/or playing in a band, physical activities, occupational and speech therapy, and physical activities, such as gym, swimming, and horticulture. Demographic variables include co-morbidity, illness severity, age, length of hospital stay, duration of offending history, and the nature of the index offence. These factors make for a diverse population. The amount of data collection for these aspects alone in a quantitative RCT would have required a large team of research assistants. This aspect alone was problematic in terms of time, resources, project management, and energy, whilst maintaining the duties of an NHS clinical lead post.

The qualitative design required the development of a semi-structured questionnaire as a further strategy of enquiry that could capture the observations and experiences of the music therapists at key points during the treatment intervention. Crotty's (1998) ideas give credence to this framework in which there are both objective and subjective aspects to this plan of action. The analysis of which can link the method to the outcome through a triangulation process in which these qualitative findings are correlated with the quantitative findings of the primary outcome

measure PROQ2. The statistical analysis of the small sample size could indicate an over-optimistic effect size in an underpowered study therefore the quantitative analysis was not considered to be of primary interest in this the present feasibility study. Extensive qualitative analysis and investigation towards exploring trends of change in the treatment and the control arms of the study was planned by dividing the treatment and control arms into those who fell on or above the median in variables of age, length of stay and duration of offending history, Following which these variables would then be correlated against the treatment effect in order to explore the trends of difference in each arm across these variables. This constitutes a detailed investigation that did not involve multiple testing.

In tailoring the study for the treatment context, consideration was given to the gaps in the research knowledge. McMurren's (2006) expert paper in forensic mental health research identified the greatest need for research-based evidence for clinically effective treatment for men with primary diagnoses of mental illness in high-secure hospitals.

The above factors led to on-site discussions with the NHS Trust Forensic Research Leads, managers, team members, psychology leads, research supervisors, advisers, and peers at the Institute of Psychiatry, Health Service, and Population Research Department, and at Anglia Ruskin University, toward implementing an ethically approved study.

A large RCT proposal was not feasible or acceptable at the research site for several reasons. The configuration of clinical service in this large hospital, which treats a total of approximately 400 patients, is divided into separate directorates, which are linked to specific diagnoses. Each directorate has its own management team and its own, different, over-arching treatment philosophy. Treatment interventions, such as music therapy, must be carefully planned and introduced on these gender-specific locked wards. Music therapy was already available to those who are assessed to benefit from it and who are referred. There are insufficient staff resources for music therapy to be readily available as standard care. Furthermore, on submitting a preliminary proposal to the Academic Research Unit, the management team was clear that they could not support the logistics in terms of staff resources to recruit or deliver a quantitative RCT across all the directorates. The amount of co-ordination that this would take in such a large hospital could only be undertaken through a future study that is coordinated and supported at a higher level through the research institute of this NHS trust. Knowledge of the hospital and the meticulous care to risk management, human rights considerations, and research with incarcerated people indicated that there would have been a very low uptake for a hospital-wide

recruitment and high attrition rates. The high numbers of patients who would have been excluded from the trial by their MDTs if they had any doubts or insufficient information about the evidence base and suitability of the treatment intervention were prohibitive factors to gaining ethical approval for a quantitative RCT. Enormous amounts of energy would have been expended in preliminary work to access areas where services were not already established and to build supportive relationships.

Instead, it was agreed that a single-site, randomised controlled trial of mixed methods in one directorate of the hospital was pragmatic and ensured some conformity of diagnoses in the study population. Arts therapies service provision was arranged so that music therapists were allocated to cover specific wards where they build relationships with staff, thereby promoting acceptability of a relatively new intervention, prior to offering it to patients. Music therapy was introduced to this hospital only 10 years prior to the study, compared with art therapy and occupational therapy, which had been established over 20 years prior. Referrals from the various wards to the arts therapies department were sent via a central therapies and education department referral system.

By ensuring ethically approved research standards with participant informed consent within the clinical setting, the aim was to gain organizational support to reliably test and attribute specific changes to the intervention. By using four outcome measures across a range of outcomes, the objective was to evaluate changes in how subjects relate to others, as well as changes in levels of dissociation and empathy. A nursing observational measurement was used to ascertain whether relational changes were replicated on the ward. Levels of risk, verbal and physical aggression to self, others, and objects will be recorded throughout as a baseline.

Bearing in mind that MDT standard care must continue uninterrupted whilst the study is implemented, and that some patients were not available at the proposed times of the treatment groups, the patient–preference methodology (Torgeson, 1998) facilitated the recruitment of a sufficient number of participants from the population under investigation.

The development of this methodology was a collaborative process undertaken with the forensic advisor to this study. The chosen methodology provided the patients with a degree of choice, thereby reducing the potential for disgruntlement for patients who might, in a larger-scale study, have been randomised to the control group, but who may have preferred the intervention. This methodology was a pragmatic choice, due to the limitations of recruitment, which are inevitably

imposed within the high-secure hospital regime. In this way, it was possible to recruit the sample size, which the power calculation required from the overall mental health directorate population, whilst respecting the human rights of incarcerated people. Ethical approval was granted by the local ethics committee through the integrated research application system (IRAS).

Partial randomization was possible, as follows:

- (a) patients who have no strong preferences and, therefore, consented to randomisation;
- (b) patients with a preference who still consented to randomisation;
- (c) patients who refused randomization who would still receive treatment if available at the required time or who chose to participate in the control arm, thereby opting for their treatment of choice.

Considerations for Consent includes the potential of a change of relationship with a healthcare professional. The PI did not have direct clinical contact or a therapeutic relationship with any of the participants, other than at the initial recruitment stage and at follow-up to request patient feedback. The research assistants who administered the outcome measures were not personally involved in the informed consent procedure. Nurses were involved in encouraging their patients to choose their level of consent appropriately. Possible misunderstandings were considered, for example with those who have difficulty with English, the aim was that no misunderstanding could occur, as interpreters are employed when required when resources allow. The risk of intrusion or coercion is a constant factor, which is observed by nurses for all interactions with patients. Those who were invited could choose whether or not to participate from three different levels. If they chose to participate in the treatment groups, they could still choose whether or not to attend the sessions. Nursing staff closely monitored this so that patients did not feel compelled to attend.

6.3 Research question

The research question to be asked in this study is: Can manualised (G-CAMT) be an effective and feasible intervention in secure multi-disciplinary treatment settings for in-patient offenders?

6.3.1 Objectives

- To determine whether G-CAMT, in addition to standard MDT care, can help patients to move forward through their treatment pathway more quickly compared to the control group.
- To ascertain the effectiveness and acceptability of the treatment manual to therapists and patients (qualitative).
- To ascertain the clinical effectiveness of 16 sessions of G-CAMT with male patient residents of the mental health directorate of this hospital compared with standard multi-disciplinary treatment.
- To ascertain whether G-CAMT is effective with treatment-resistant patients and those with low therapy motivation who are willing to work with music, to improve their relating to others (primary study outcome) and to improve social functioning.
- To ascertain whether impulsivity is reduced and self-reflection develops in those in the treatment group compared with the control group.
- To determine whether the intervention helps patients to improve in the following secondary outcomes:
 - a) Abilities of self-expression in music; motivation for change; self-esteem; emotional regulation; distress tolerance; relational competence; and social relationships.
 - b) Development of relational skills, reduction of dissociative experiences, and development of empathy.

6.4 Experimental hypotheses:

The primary hypothesis

Musical improvisation delivered to men who have committed violent offences and who are receiving secure hospital treatment in groups, through manualised G-CAMT will improve their relating to others compared with the control group who receive standard multi-disciplinary treatment as usual, as measured by The Persons Relating to Others Questionnaire (PROQ2) (Birchnell & Evans, 2004)(Appendix 3a) and The Manual for the Chart of Interpersonal Reactions in Closed Living Environments (CIRCLE) (Blackburn & Glasgow, 2006) (Appendix 3b). The independent variable (IV) is jointly-created musical improvisation (treatment versus control). The dependent variables (DV) are relating to others (as defined by the PROQ2

domains) and emotional relatedness (as measured by changes in empathy and dissociative traits).

The secondary hypotheses

The second hypothesis

Men in the treatment group will show an improvement in their emotional relatedness after 16 sessions of G-CAMT, compared with those in the control group receiving standard care as measured on the Basic Empathy Scale (Jolliffe & Farrington, 2006) and the Multiscale Dissociation Inventory (MDI) (Briere, 2002).

The third hypothesis

A randomised controlled trial is feasible in a high-secure hospital treatment setting, when a patient preference methodology is used, as measured by the Attkisson and Greenfield (1994) Client Satisfaction Questionnaire-8 and Self-Report Music Therapy Client Satisfaction Questionnaire adapted by Beeley & Compton Dickinson (2010) from Odell- Miller, Hughes and Westacott (2004).

Table 6.1 states the primary hypothesis with the selected fit for purpose outcome measures followed by the second and third hypotheses with outcome measures.

Table 6.1: The hypotheses with selected outcome measures.

Hypothesis under investigation	Outcome measures
<p>1. Primary Hypothesis: Musical improvisation delivered to men who have offended and who are receiving secure hospital treatment in groups, through manualised cognitive analytic music therapy, will improve their relating to others compared those receiving standard multi-disciplinary treatment as usual.</p>	<p>Self-report measure:</p> <p>The Persons Relating to Others Questionnaire (PROQ2) (Birchnell & Evans, 2004) is a self-report measure, which has been psychometrically tested on non-patients from two sources, on patients from three psychotherapy clinics, and in prison services.</p> <p>Observational rating:</p> <p>Blackburn and Glasgow (2006). Manual for the Chart of Interpersonal Reactions in Closed Living Environments (CIRCLE).</p>
<p>2. Second hypothesis:</p> <p>Men in the treatment group will show improved emotional relatedness compared with those in the control group receiving standard care only.</p> <p>3. Third hypothesis (Patient Satisfaction):</p> <p>A randomised controlled trial is feasible in a high-secure hospital treatment setting, when a patient preference methodology is used, as measure by the Attkisson and Greenfield (1994) Client Satisfaction Questionnaire-8 and Self-Report Music Therapy Patient Satisfaction Questionnaire adapted by Beeley and Compton Dickinson (2010) from (Odell-Miller, Hughes, and Westacott (2004).</p>	<p>Self-report measure 1:</p> <p>Basic Empathy Scale Self-report (Jolliffe & Farrington, 2006). Measures development of empathy.</p> <p>Self-report measure 2:</p> <p>Multiscale Dissociation Inventory (MDI) (Briere, 2002). Measures levels of dissociation.</p> <p>Self-report Music Therapy Patient Satisfaction Questionnaire adapted Beeley and Compton Dickinson (2010) from Odell-Miller, Hughes and Westacott (2004)</p> <p>Attkisson and Greenfield (1994) Client Satisfaction Questionnaire-8 and Service Satisfaction Scale 30 in Psychological Testing: Treatment, Planning and Outcome Assessment. San Francisco, CA, Lawrence Erlbaum.</p>

6.5 METHOD

The preliminary activities involved presenting the research proposal to the directorate leads, writing to consultant psychiatrists and their multi-disciplinary teams, writing to all the ward managers involved, and keeping them informed of the ethical approval process. Recruitment was preceded by a flyer for patients to read, which was displayed on each of the five identified wards. These documents can be seen in Appendices 2a-d.

Providing information prior to the start of the study

An information letter was then sent to all patients on the identified wards, inviting them to consider participating in the study. Named nurses also received a copy for the patient file and their information. One week later, the nurses on the ward co-operated to gather the patients together at a time which suited the ward schedule so that the music therapists and PI, who then visited the wards, could introduce the patients, as a group, to what music therapy involved, what to expect, and to introduce them to some musical instruments. The informed consent forms (Appendix 2e) were then given to patients who expressed an interest in discussing this with their named nurses. Some patients wanted to participate and signed the forms immediately; they were, however, encouraged to reflect and discuss their decision with trusted staff once the music therapists had left. Signed consent forms were posted back to the Arts Therapies Department for the senior evaluation officer to collate and randomize.

All potential participants were capable of giving informed consent. A full explanation was given with clarification that the patient's decision would be respected and opportunity to change his mind as to whether he participated or not. Assurance was given that whatever his decision, this would not detrimentally affect his ongoing treatment or prospects. Patients were invited to reflect for at least 24 hours prior to making a decision, considering overnight and also in consultation with their named nurse. Depending on nursing shifts, the patient may wait a few days whilst he mulls over the implications and asks for his named nurse's view. If there was loss of capacity to consent during the study due to deterioration of mental capacity, the participant would be withdrawn from the study. Data already collected with consent would be retained and used in the study. No further data would be collected or any other research procedures carried out on or in relation to the participant. Data already collected was of value, even if a patient dropped out. Data provided information about possible reasons for participant drop out.

Initial Individual Assessments were conducted on the ward by the music therapists, thereby providing each participant with the opportunity to build an initial therapeutic rapport, to have an introduction to the instruments, and an opportunity to consider with the music therapist what they hoped to achieve from the intervention. The latter is called the ‘target aim’, thus creating a positive slant to the ‘target problem’, which would be discussed at the start of a CAT treatment.

Completing Outcome Measure Questionnaires: Interviews took place on the patients' ward. These were administered in a private room in the presence of a staff member who was known to the patient. The research assistant undertaking the interviews and the patients were masked to the hypotheses. The research assistants were trained by the PI to complete the three self-report measures with each patient at a mutually agreeable time and within 45 minutes duration. Patients who received the intervention were encouraged to fill in outcome measures at the start, middle, and end of treatment, as well as at follow-up eight weeks

Patients who were randomised to the control group were offered treatment through the hospital referrals system once the study had completed implementation. Patients in the treatment arm were invited to complete the Music Therapy Patient Satisfaction Questionnaires at the end of the implementation. This provided an opportunity for them to rate their experiences on a continuum, and to give written feedback on their experiences of being involved in this study. All patients involved were taken through the informed consent procedure prior to entry into the trial. Some had already expressed interest in music therapy. All continued to receive their standard care.

After the follow-up period and final measurements were taken, the final report and initial findings of patient satisfaction were prepared and presented to the management team at the hospital. They were then disseminated at the annual conference of the Association of Cognitive Analytic Therapy, Manchester (2012), the Qualitative Research Mental Health Conference, Nottingham University (2012), and at the International Society for the Psychological Treatment of Schizophrenia, Birmingham (2012). The treatment manual received enhancements due to developments in musical mindfulness techniques, in response to the music therapist's feedback, and with a view to its introduction into the treatment pathways at this hospital.

6.6 Ethical considerations

Application through the integrated research application system (IRAS) for ethical approval was

granted in January 2011. (Appendix 7)

In the application, inclusion risks were identified as follows:

1. Risk of research procedures or withholding standard procedure
2. Risk of a new therapy.
3. Risk of breach of confidentiality.
4. Risk benefit versus risk of potential for harm.

1. Risk of research procedures or withholding standard procedure: There was already a waiting list for music therapy, so this project increased the availability of treatment.

A standard 'dosage' of CAT in community NHS services is the same as in the research project: 16 sessions. Maintaining research conditions with a follow-up period for a longer period than eight weeks was not feasible in this environment without impeding patient progress to other interventions.

2. Risk of new therapy: Two pilot projects had been completed, so the model was not new to this hospital. There was prior evidence of efficacy and of anecdotal patient satisfaction, as well as support for MDTs and consultant Psychiatrists.

G-CAMT was developed at and had been available at this hospital over nine years. G-CAMT has a developing evidence base above that of psychodynamic music therapy in forensic treatment. One objective of the model is to reduce the risk of disturbance and re-traumatisation to the patient, which could occur through clinical techniques that have not been developed specially for the treatment context, and the patients therein. By developing and following a treatment manual, the aim is to reduce the risk of over- arousal, over-stimulation, or harm to self and others through the misuse of instruments through impulsive or dangerous responses.

3. Risk of breach of confidentiality: Risk of breach of confidentiality is minimal, as the music therapists follow the professional code of practice of the HCPC and The British Association of Music Therapy, as well as abiding by the NHS Trust policies.

Data was coded by number. No identifying patient data was permitted to leave the hospital without permission of the medical director. As a standard practice, data leaving the hospital is made anonymous.

Sensitive information There is a rare chance that offenders may, within the context of group therapy, disclose their own experiences of childhood sexual abuse or domestic violence. The hospital has specific procedures, which must be followed in order to ensure that patients who disclose distressing events have appropriate support. The music therapists are fully informed of the procedure for reporting risk issues in patient continuous multidisciplinary notes. The two music therapists received regular, weekly clinical supervision to ensure their own mental health was not detrimentally affected.

Child protection vulnerable adult protection: If an abuse were to have been disclosed by a patient, an investigation would be pursued to ascertain whether the alleged perpetrator was still alive. This would be reported in line with Trust Policies and within child and vulnerable adult protection policies.

Risk of violent retribution: Therapy group rules were laid down that the nature of individual offences were only openly discussed in individual psychology or offence-based psychology groups. Offence-related behaviour could be reflected on and considered non-verbally in music therapy. One purpose of music therapy is to enable those who struggle to express themselves with words, to work non-verbally in music therapy to dissipate creatively any negative or difficult feelings within the jointly-created music. Any cause for concern for the safety of patients or staff would be reported as a standard procedure to the ward manager and responsible clinician for that patient.

Consideration of risks for the researchers themselves

Over involvement with patients was minimised through weekly supervision and weekly peer group support. Harm to self from others or from instruments if used as weapons in sessions, or secreted and taken back to the ward was covered by sessions being observed by nursing staff. Security and risk procedures are followed rigorously.

Protection of patient identities and coding system

MDT s were informed of patients who expressed an interest in participating, so that this could be discussed with them in their ward rounds. The music therapist attended the ward rounds. They received an explanatory letter from the chief investigator.

As part of their duties, the music therapists considered with the MDTs whether those interested in being referred might participate. The decision of whether a patient may be invited to participate is held with the responsible clinician and the multidisciplinary team, but not with the research team.

Protecting confidentiality

The music therapists, who delivered the treatment, were invited to engage with the clinical teams to identify suitable patients and to advise the PI accordingly. The music therapy team has access to continuous, electronic patient notes. The PI, who was on permanent contact within this trust, based at this hospital, with the help of her assistant, anonymised all the participants' details, by coding their details and keeping the code separate and secure. All security and confidentiality policies and procedures for the hospital and the forensic division of this NHS trust were followed at all times with regard to patients' rights, confidentiality, treatment, and care. For work off-site via email, patient initials and ward names were never to be used together, codes were assigned, and this process was overseen and approved by the Trust Research Leads.

Scientific and Statistical Review:

The proposal was peer-reviewed and approved within the host NHS Trust Research and Development Committee. The study was peer-reviewed at Anglia Ruskin University, at the Institute of Psychiatry, Kings College, London, where the ethical application was submitted, by the external forensic advisor to this study and by the forensic research leads in the NHS Trust. Future peer review will occur through a pending international journal publication.

6.7 Sample

The study population is men who have serious mental disorders and who have committed violent offences. All participants were over 18 years of age. All participants have committed offences and are receiving secure hospital treatment. Patients are residents in high-secure settings with a diagnosis of schizophrenia or serious mental disorder with or without comorbid personality disorder. They will have reached a relatively 'symptom-free' state through stabilisation on medication, thus reducing the effect of actively psychotic features. They are, therefore, able to give informed consent and are compliant and stable on medication in their current living environment.

Sample characteristics:

1. Men who have committed offences
2. Detained under the Mental Health Act 2008 for high risk behaviours
3. Age 18-65 years
4. Resident at this high-secure hospital in the mental health directorate

In the NHS Programme on Forensic Mental Health Research series and Development, McMurran (2006) verifies that the diagnoses of personality disorder suffer problems of validity and reliability. Such diagnoses can be unreliable and the implications of co-morbidity are such that McMurran (ibid) stated that clinicians should always assess for personality disorder. McMurran (ibid) also highlighted that treatments should take into account multiple diagnoses. There are research implications because ‘pure’ cases of serious and enduring mental illness or of any personality disorder are a rarity. This aspect as a variable is taken into account in the demographics table. (7.1)

6.8 Inclusion and exclusion criteria

Inclusion Criteria

- Men with severe enduring mental illness.
- Committed violent offences.
- Receiving standard Multi-disciplinary treatment programmes.
- Aged between 18 and 65 years old.
- Who have a primary diagnosis of mental illness.
- Who have an IQ of over 70, with the capacity to give informed consent.
- Who have resided at the hospital for over six months.
- Who have sufficient verbal comprehension to complete the outcome measures.
- Whose acuteness of psychotic illness does not preclude the completion of the outcomes measures.
- Who may have an interest in working therapeutically with the non-verbal medium of music.
- Ethnic Origin: patients will be recruited across all ethnic groups.

Exclusion Criteria

- Men who have a diagnosis of organic brain disease.
- Men who have a physical disability which impairs movement to a degree which precludes active participation in the group process.
- Men with serious physical illness.
- Men with an IQ lower than 70.
- Men who are already attending music or art therapy.
- Men who have insufficient verbal comprehension due to English not being their first language or if we are not able to secure/fund translators (every effort will made to do so).
- Men with limited literacy or intellectual skills to complete tools and service user evaluation.
- Men who are Actively psychotic at the time of recruitment (patients at this hospital are not referred to psychology or arts therapies until they have been assessed by their consultant as 'symptom-free' of positive symptoms of florid psychosis)
- Men who have been admitted within the past six months.
- Women who are residents at this hospital in gender-specific services.

6.9 Power calculation to determine the sample size

A power calculation was made based on a sample of N=20 (N=16 after attrition; N=5 were randomised). The power calculation was made in reference to the validating paper of the primary outcome measure (Birtchnell & Evans, 2004) after the pilot project, prior to this main study. A sample of 20 patients was required for the trial assuming one group, an alpha of 0.05, 80% power, an estimated mean difference of 17.90, a standard deviation of 36.50, and effect size of 0.68.

6.10 Sampling strategies

From the study population of N=102, 35 patients did not meet the inclusion criteria, 15 refused to participate, and 32 patients provided other reasons for not participating, such as a lack of availability. N=20 consented to participate in the study (see Fig. 6.1).

CONSORT 2010 Flow Diagram

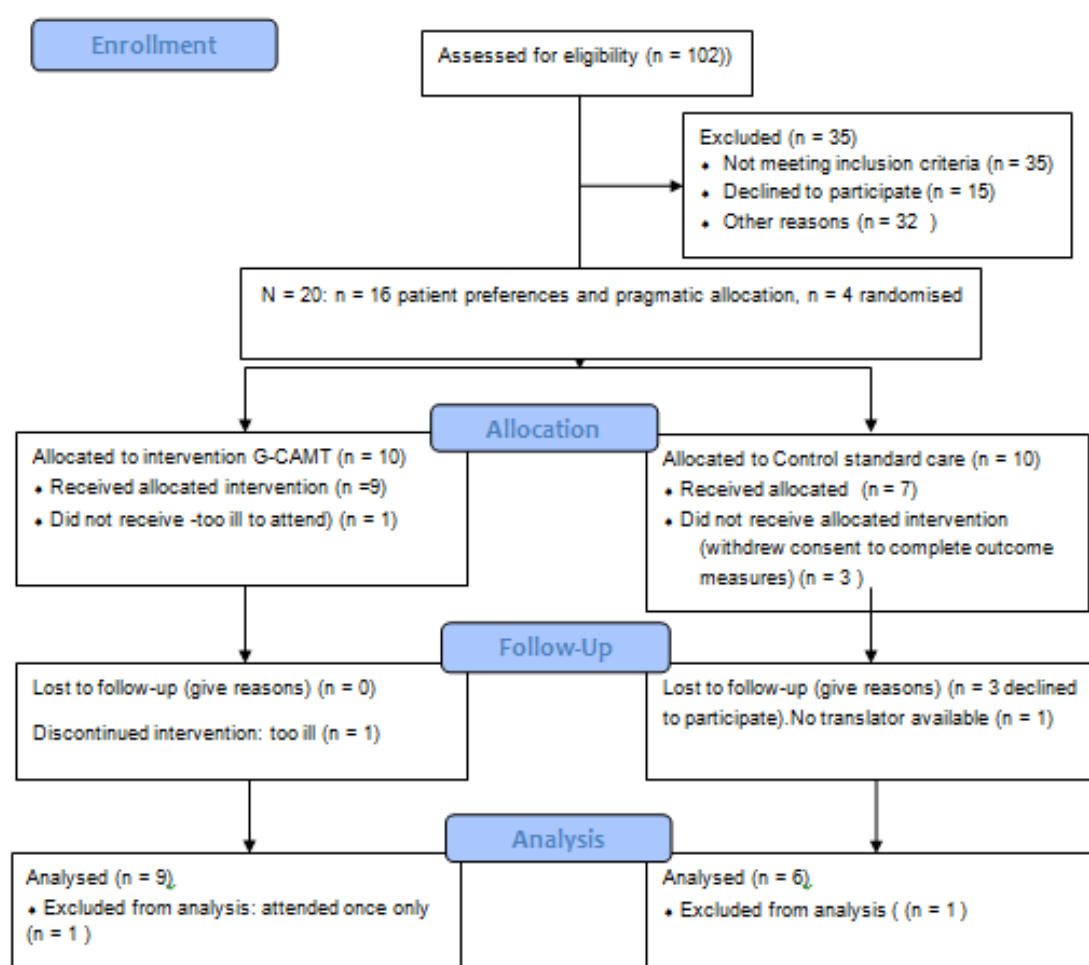


Figure 6.1: Consort diagram of the sampling strategy.

Patient Allocation (see Table 6.2)

(a) Choose to participate in the treatment group

(b) Randomisation: to either the treatment or the control group

(The former choice was dependent on patient availability on the day and time allocated for treatment groups. Each of the two treatment groups could have a maximum n=5. This was due to hospital security risk procedures.

(c) Choose to be in the control group with respect to patient choice that they did not want music therapy, but did want to help.

Table 6.2: Patient preferences to treatment, randomization or control.

Group A Treatment	Group B Randomisation	Group C Control
Chose MT	Control or MT Choice 1. OR 2. to be randomly allocated.	Chose Control Group
N =11	n=3 n=1 chose Control then MT	n=5

Attrition rate: Of the 20 patients recruited, three refused to participate after having given consent, two of those gave no reason, and the other one had suffered mental health deterioration. A fourth patient required an interpreter. Unfortunately, it was not possible to acquire this service within the time span of the study; therefore, this patient was unable to participate, as he had initially requested to be in the control group. He was offered music therapy after the study had completed. One patient allocated to treatment attended only once, and was too ill to continue. He was on an admission ward. Final numbers included ten patients were randomly allocated to the two music therapy treatment groups in the treatment arm, and six patients were randomly allocated to the control group.

6.11 Materials: Assessment Instruments

For the purposes of this study, outcomes were considered which were based on clinical need and on how to measure the distinct active ingredients of the music therapy treatment process. Eight years of on-site development, modeling, and piloting, as described in chapter 4, as well as internal and external research supervisory discussion and debate, were undertaken prior to the selection of these outcome measures.

Table 6.3 shows the selected outcome measures, three of which were completed by the patients with the research assistant. The observational measure (CIRCLE) of patient behaviour on the ward was completed independently by nursing staff.

Table 6.3: Measurement tools for psychological and forensic domains with measurement points.

Type of Instrument	Description of measure	Baseline period before randomisation	Mid-point	End of treatment	Follow-up at 8 weeks
Interpersonal relating	PROQ2 Self-report	X With research assistant	X	X	X
Interpersonal relating	Basic Empathy scale Self-report	X With research assistant	X	X	X
Interpersonal relating	Multi-Scale Dissociation Inventory (MDI) Briere (2002) Self-report	X With research assistant	X	X	X
Forensic Domain:	Relationship Chart of interpersonal reactions in a closed living environment. (Blackburn, 1999). Observational rating	X by Nursing Staff (external to treatment groups)	X	X	X

6.11.1 Primary Outcome Measure: PROQ2 (Birtchnell & Evans, 2004)

The primary outcome measure is called The Persons Related to Others Questionnaire (PROQ2). This tool is a self-report measure composed of 98 questions. This measure differentiates the ways that people respond either positively or negatively to the fundamental human needs of both closeness and distance from others. The questionnaire has been psychometrically tested on non-patients from two sources, on patients from three psychotherapy clinics and in prison and medium-secure hospital services. PROQ2 has been validated for reliability and internal consistency by Birtchnell and Evans (2004).

Birtchnell's relating theory (1993) was developed from the attachment theories of Bowlby (1964). Birtchnell (ibid) considered that aspects of closeness distance openness and lowerness are considered to be advantageous states of relatedness, which can also be found in other animals in their relating behaviour in a simpler form. Each stage of relatedness represents an innate objective which is vital for survival, which over the course of maturation it is hoped people can attain and maintain competently or if not, this leads to interpersonal difficulties. This may manifest as avoidance, clinging, or living in a state of constant dread of losing a particular way of relating. Whilst Birtchnell (ibid) and Ryle (2002) developed unique theories on relating, the innovations of the latter and the method of measurement of the former are compatible in this author's view, because they are both based in attachment theory. The PROQ2 was used in a comparative study of CAT (Birtchnell and Denman, 2010).

There are eight domains of relatedness in the PROQ2, each of which has qualitative properties which are described on the two charts below. The octants in Figure 2, below, describe the negative qualities, many of which are common in people who have committed offences. Figure 3 describes the positive qualities within each of the same domains, which indicate healthy relating to others.

These relating properties are defined by Birtchnell (1993, 1997) in terms of how the individual is able to relate to others in different situations. For example, when a person is in a position of what Birtchnell (ibid) calls 'upperness' or authority, or as the caring parent to the helpless child, or in a neutral position, such as within a collaborative relationship, or from a lower position, which might be felt by the individual as subordinate.

These upper, neutral, and lower positions correlate with the horizontal and vertical axes of the PROQ2 Octant, which describes proximities of distance and closeness to others. For example, Upper Distant = UD, Neutral Distant = ND, and Lower Distant = LD.

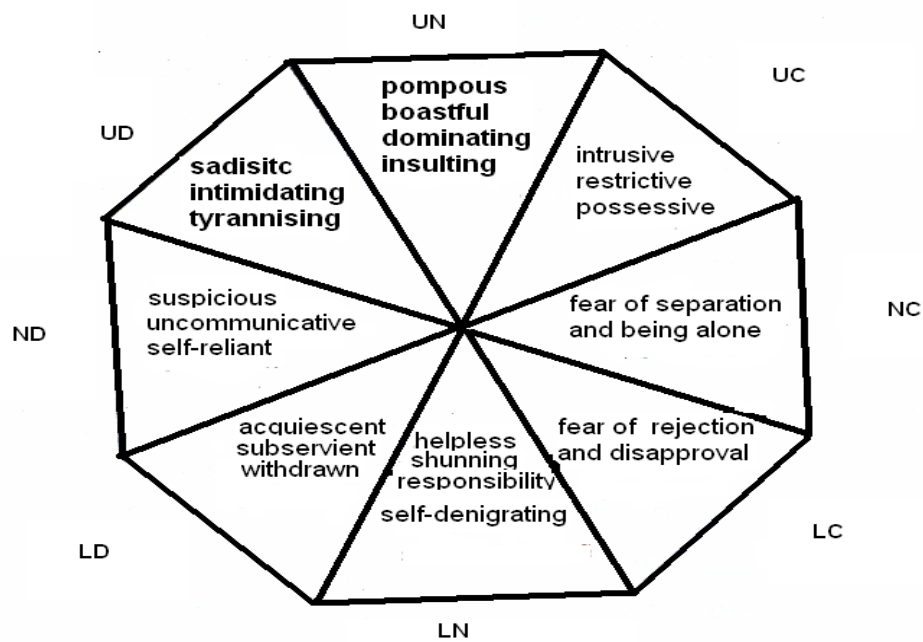


Figure 6.2: The negative qualities of the PROQ2 Octant

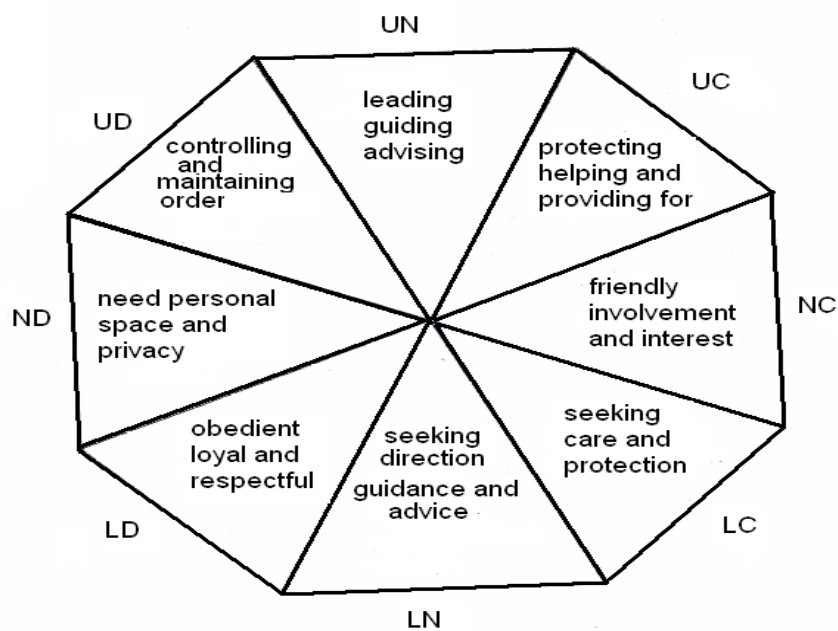


Figure 6.3: The positive qualities of each octant of the PROQ2 Octant.

Patients in high-secure hospital treatment have resorted to dangerous ways of relating, which ultimately led to violent behaviour and incarceration. The upper distant domain, which records negative, sadistic, and intimidating behaviour as opposed to positively controlling and maintaining order, is of particular interest.

PROQ2 Psychometric properties

Psychometric data on the PROQ2 were published in Birtchnell, Falkowski, and Steffert (1992) and Birtchnell, (1993, 1996, 1999) also results in 107 male prisoners in Birtchnell and Shine (2000). More extensive psychometric data on the PROQ2, on samples of 276 non-patients and 432 psychotherapy patients, are provided in Birtchnell and Evans (2004). Inter-octant correlations using Spearman's rho were carried out by Birtchnell and Evans (2004) to show scale scores between patients and non-patient samples (see Fig. 4). The internal consistency for the majority of non-patient and all the patient scores was reported as very good. This was also the case in the Birtchnell and Shine (2000) study, which was taken from male prisoners.

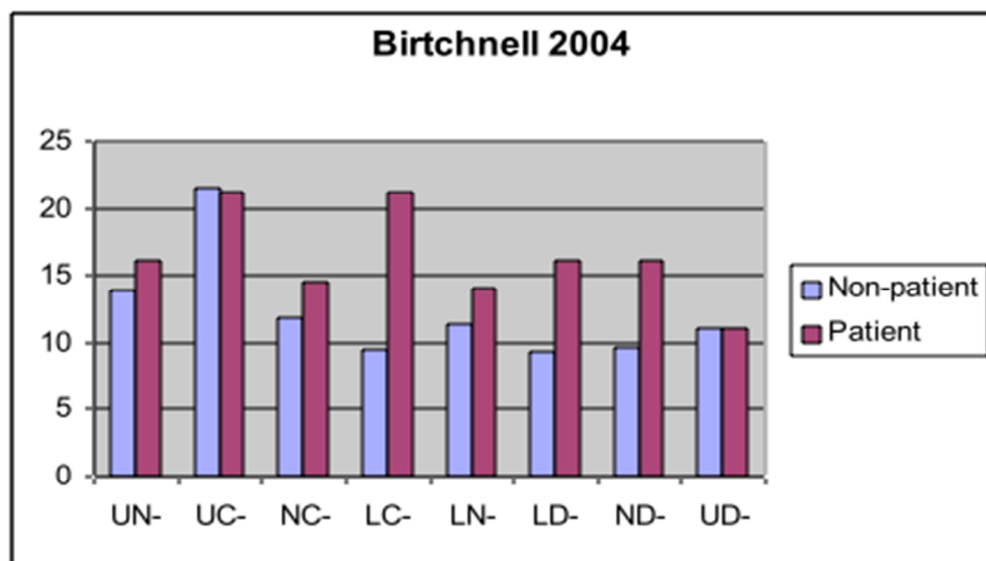


Figure 6.4: Scores of patients versus non-patients in each of the eight PROQ2 domains. (Birtchnell and Evans 2004).

6.11.2 Secondary Outcome Measure: The Basic Empathy Scale (BES)

Jolliffe and Farrington (2006) validated this tool on an initial sample of 363 adolescents male and female in year 10 in Hertfordshire, England. Jolliffe and Farrington selected this cohort because they had conducted a meta-analysis (2004), which demonstrated that young people have stronger relationships between low empathy and offending than adults. This tool measures two domains called ‘cognitive’ and ‘emotional empathy’, as well as providing a ‘total score’.

6.11.3 Secondary Outcome Measure: The Multi-scale Dissociation Inventory (MDI) (Briere, 2002)

The MDI is normed and standardized on 444 trauma-exposed individuals from the general population, and validated in clinical community and university samples (Briere, 2002). Whilst the MDI is not specific to the forensic hospital population, Briere stated that it has been found to have good psychometric qualities in both normative and validation samples. The MDI is a Likert scale. The tool measures six domains, namely disengagement, de-personalization, de-realization, emotional constriction, memory disturbance, and identity dissociation. For the purposes of both research questions, we measured the two relevant domains, including ‘emotional constriction’ and ‘disengagement’. The implication may be that if an individual becomes more related to others and to himself, he will be less disengaged in the process and become more aware of the emotions arising within him and in response to others, therefore, less emotionally constricted. The remaining four domains are very specific to the psychological defences of dissociation, however, these patients will also manifest with other psychoanalytic defences such as repression, suppression, reaction formation and altruism.

6.11.4 Observational Rating: The Chart of Interpersonal Reactions in Closed Living Environments (CIRCLE) (Blackburn & Glasgow, 2006)

CIRCLE is a 49-item observer-rated questionnaire, which assesses the interpersonal and social behaviour of hospitalised psychiatric inpatients over the preceding month (Blackburn & Renwick, 1996). It was completed on the ward by nursing staff to report changes in relating outside the treatment group. This tool was developed specifically for closed hospital environments. CIRCLE has eight domains (Blackburn, 1992). The score in each domain indicates the prominence of that domain’s style within the participant’s interpersonal repertoire of behaviour. For the purposes of this short study, we analysed four of those domains, namely

‘hostile’, ‘withdrawn’, ‘friendly’, and ‘sociable’, as these relate to the primary research question. In a future study, over 32 sessions, it would be expected to see more change in all the domains, and, therefore, to analyse them all. The purpose of the observational measure is to reduce the chance of the Hawthorne effect (McCarney et al., 2007), in that changes in behaviour may be observed as genuinely attributable to the independent variable rather than merely to a change in the environment of the participant and the levels of attention which they are receiving during treatment.

The CIRCLE observational measurement is conducted by nurses who observe and record on-ward behaviours to ascertain whether improvements in relating are replicated outside of the treatment group in on-ward interactions with others. The questionnaire is constructed of 49 questions, which explore relational aspects such as whether the patient is joining in with group activities, accepting rules, demanding attention, keeping himself to himself or shirking responsibilities.

6.11.5 Satisfaction Measure: Attkisson & Greenfield (1994) Client Satisfaction Questionnaire-8 and Service Satisfaction Scale 30

Patient satisfaction was measured on the Attkisson and Greenfield (1994) Satisfaction Questionnaire-8. This tool covers different aspects of the service received, the help received, and the levels of satisfaction.

6.11.6 Satisfaction Measure: Music Therapy Patient Satisfaction Questionnaire

This self-report music therapy patient satisfaction questionnaire was developed by Beeley and Compton Dickinson (2010, unpublished) from the research findings of Odell- Miller, Hughes, and Westacott (2006). The music therapy patient satisfaction questionnaire is a Likert scale, in which patients can rate from ‘strongly disagree’ to ‘strongly agree’ whether the therapy was helpful, enjoyable, and in what ways. There is space for patients to write in their own words their feedback and a rating scale along a continuum on which they can mark a point ranging from ‘I did not have a good experience in therapy’ to ‘I had an excellent experience in therapy’.

6.11.7 Semi-structured Interviews

A semi-structured interview was created to record the two music therapists' observations and experiences. (Appendix 6) This was undertaken at four time points with the PI and, subsequently, analysed using Interpretative Phenomenological Analysis (IPA) (Smith, 2009).

6.12 Procedure

Recruitment took place across five wards within the mental health directorate, which has a population of 102 patients. Patients in the treatment arm were randomly allocated to two clinical treatment groups of five patients each. This was, however, subject to their availability in either the morning or the afternoon. Patients already receiving music or art therapy were excluded from the study. Current interventions took priority over consent and participation in the study. As recommended later in the NICE guidance (NICE, 2013), the research intervention is additional to existing standard multi-disciplinary team (MDT) treatment, which is tailored to each patient's needs.

In preparation for the G-CAMT research trial, the music therapists were given an introductory two-day training in the CAT model. They received weekly supervision throughout the research trial from the PI (SC), who is a registered music therapist, and accredited cognitive analytic psychotherapist and supervisor. The clinical supervision facilitated reflections on the group transferences, counter-transferences, and musical processes, and provided guidance towards mapping out in diagrammatic form the groups' developing relating patterns. The maps provide a visual aid by which recognition of reciprocal role procedures were understood by the music therapists. The music therapists subsequently mapped out these diagrams collaboratively with their treatment groups in order to enhance group recognition and insight into relating patterns. The mapping work, which took place within the sessions, provided a focus for commonality of experience through which group cohesion developed. Twenty participants were recruited. The demographics were tabulated. The treatment and control groups ultimately were not finely matched. This imbalance of matching was partly due to attrition and to the restrictions on patient availability at the time of the treatment groups.

The recruitment procedure:

1. Identify patients that meet the inclusion criteria.
2. Send the information letter to clinicians.
3. Discuss with the responsible clinicians (RCs) of these patients which patients they consider to meet the inclusion criteria.
4. Request permission from chief investigator or her representative (research assistant) to meet these patients.
5. Meet patients and ask if they are interested in participating.
6. Give them information and choice on levels of participation:
 - a) Treatment
 - b) Standard care followed by treatment
 - c) Standard care with measurements, no treatment.
 - d) Not interested
7. Ensure that those who give consent will receive the treatment.

The senior evaluation officer used the computerized randomization programme 'R' to allocate participants (see Consort diagram 6.1.).

A list of names for the treatment arm was then sent to the two music therapists, who allocated the participants to the two treatment groups within the treatment arm. Allocation to the two treatment groups was based primarily on the patient's individual timetable and availability at the time of the proposed music therapy groups, rather than on personality compatibility within matched clinical groups. All participants had an initial individual session on their ward in preparation for starting the treatment groups. Both music therapy treatment groups were run on the same day, one in the morning and one in the afternoon.

The treatment group sessions were delivered once weekly for a 90-minute session over a pre-agreed time-limited period of 16 sessions. A dose, for example, of music therapy being delivered two times a week for 90 minutes (Chen, 2013) is a controversial issue because of the expense of service delivery by music therapists in the United Kingdom National Health Service (NHS) and the staff resources required for moving patients who are escorted to treatment areas, and then observing the sessions to ensure safety. The systematic review by Gold et al. (2005) indicates that dose-response relationship, potential confounding variables, and sustainability of the treatment require further investigation. This will be discussed in chapter 11.

6.13 Data collection

Procedures for data collection

A nurse was recruited and trained to work with arts therapies staff to administer the three self-report outcome measures at four time points to individual participants in a maximum of 40 minutes. A timetable of patient availability was agreed on with nursing staff, by which each interview, at each of the four time points, took place on the ward for each of the patients at a mutually-agreeable time of day. A baseline measurement was taken after recruitment, but prior to allocation to the treatment or control arm. The second administration of the outcome measures took place after six sessions for pragmatic reasons, due to the availability of the music therapists and co-ordination of their annual leave. This dataset was incomplete and the data collection could not feasibly occur at mid-point. Ultimately it was excluded from the data-analysis. The third set of measurements took place after the final session of the treatment phase. Finally, the follow-up measurements took place after a consolidation period of eight weeks. Research conditions could not be sustained for any longer.

6.14 Methods of data analysis

6.14.1 The R programme (Kabakoff, 2014) is a statistical and graphical programming language that provides a wide variety of statistical (linear and nonlinear) modelling, classical statistical tests, time-series analysis, classification, clustering, and graphical techniques. **R** provides functions for non-parametric tests of group differences carrying out Mann-Whitney U, Wilcoxon Signed Rank, Kruskal Wallis, and Friedman tests. The PI and the two music therapists were masked to this process. The senior evaluation officer using this programme completed randomisation to which the research team were masked.

Continuous variables in standard cars include the hours of intensity of an intervention and intelligence. The former included the hours of recreational music which were received by some participants across both arms of the trial (Table 7.2) IQ was not measured in accordance with hospital procedure.

Data analyses from all the outcome measures were conducted in the present study using the Statistical Package for the Social Sciences (SPSS) Version 20T. The data was inputted and then tested for normal distribution. The researcher created histograms (see Appendix 4b). The

distribution was skewed and the sample was small, therefore, non-parametric tests were advised in research supervision, as most fit for the purposes of this study.

The Mann-Whitney Test (Fay & Proschan 2010) was selected to make comparisons between groups. This test is used when both the treatment and the control group have completed the measures across the course of the study (i.e., there are two conditions: standard care, and G-CAMT and standard care). Each participant is only in one or the other of these conditions, thus, a rating can be taken to compare and rank the differences between the two groups at each time point. In these descriptive statistics, the median was calculated in order to reduce the effect of the outliers because the groups were not matched. The descriptive statistics of PROQ2 were transferred to a table (7.3) in which separate rows show the scores between the treatment and control arms and across time in each of the eight domains/ octants of PROQ2. The rows are further clarified with the statement of the negative and positive and qualities of each domain which is written to the left and right of each row respectively. The secondary outcome measures are tabulated similarly. The negative qualities are those which are measured therefore the score will reduce if improvement is made.

The Friedman test was selected to test change within each group across time. Intensity of standard care was recorded and monitored. (Table 7.2.) The Friedman test is the non-parametric alternative to the one-way ANOVA with repeated measures. It is used to test for differences between groups when the dependent variable being measured is an ordinal variable (for example, a Likert scale.) According to Laerd statistics (2014), the assumptions required to use Friedman's test are that there is one group that is measured on three or more occasions, (across time); that the group is a random sample of the population; and that the dependent variables (the selected outcome measures) are measured at the ordinal or continuous level.

Friedman's test can be used for continuous data that has violated the assumptions necessary to run the one-way ANOVA with repeated measures (e.g., data that have marked deviations from normality).

A demographics table was created prior to implementation (7.1). These variables were inputted to SPSS software as ethnicity, age, date of admission, age at first conviction, subsequently calculating the number of years of offending history, categorising the index offence and the mental disorder with or without co-morbidity.

Having calculated change over time and within the groups, the variables within the treatment and the control groups of age, length of stay, and duration of offending history were compared against treatment effect.

The median was calculated and the treatment and the control groups were divided into those who fell below the median and those who fell above the median. These were plotted onto separate graphs for age compared to treatment effect; length of stay compared to treatment effect; and duration of offending history compared to treatment effect across all the outcome measures.

6.14.2 Qualitative analysis:

The core processes of music therapy form the guiding principle from which subsidiary processes such as emotional relatedness and the development of empathy occur, thus, the meaning and process of music therapy dominate the analysis. The analysis identifies and draws out the main themes, filtering and funneling these into relevant categories. The manual builds up patient relating skills in a scaffolded manner (Ryle & Kerr, 2002). There are four stages of treatment, each of which is four sessions in duration, totaling 16 sessions in all.

The questions in the semi-structured interview focused on the observations and experience of the music therapists in using the treatment manual and in helping patients to observe, describe, and explore in a meaningful way. (Appendix 5c)

1. In observing how patients develop emotional recognition.
2. In observing how patients discover how to tolerate distress through musical improvisation.
3. In observing how patients develop interpersonal effectiveness through the use of improvised music and words.

The data collected was distilled in order to modify and develop the manual.

A modified form of Interpretative Phenomenological Analysis (IPA) (Smith, 2009) was chosen for the qualitative data analysis of the music therapists' semi-structured interviews. The semi-structured interviews were digitally recorded with the music therapists' informed consent. The interview schedule was developed specifically for the study. The questions posed were structured around the four stages of the treatment manual. They were designed to capture the

music therapists' experiences of using the treatment manual and their observations of patient responses at each of the four stages. This methodology enabled large quantities of transcribed data to be funneled into themes, which could then be triangulated. The key questions posed in the semi-structured interviews with the music therapists were designed to build up a picture of the music therapist's observations of developments and of the changes in patient presentation. A prolonged process of analysis followed in which the principal investigator with a research assistant as a second rater engaged in dialogue. This enabled an inquisitive approach, thereby refining the data towards drawing conclusions on the acceptability of the manual.

The semi-structured interviews from the music therapists' observations and experiences involved the transcription of 20,000 words. Exploratory comments were drawn from each music therapist, from which emergent themes were extrapolated and compared. Analysis involved funneling and refining the data through six stages, from which qualitative results were correlated against the quantitative statistics. Validation of the process was carried out with the main supervisor.

Triangulation of the negative relating qualities as measured on PROQ with positive qualities of PROQ2 as reported by the music therapists' observations and experiences. Patient satisfaction questionnaire (Attkisson & Greenfield, 1994) was statistically and qualitatively analysed. The Music Therapy Patient Satisfaction questionnaire provided data, which the researcher analysed qualitatively and triangulated against the PROQ2 qualitative domains of relating.

To test the primary hypothesis, the researcher completed the above-mentioned statistical analyses on the PROQ2, MDI, and CIRCLE. A qualitative analysis of the semi-structured interviews was then undertaken. The method employed was a modified form of Interpretive Phenomenological Analysis (IPA) (Smith, 2009). The researcher then triangulated statistical and qualitative results of the PROQ2 against the qualitative analysis of the semi-structured interviews (see Table 2). The IPA data analysis involved five stages of refining and funneling until the super-ordinate themes emerged prior to the triangulation exercise.

To test the secondary hypothesis, the researcher completed the same statistical analyses as were completed on the BES and MDI.

To test the third hypothesis, the researcher created bar charts from data collected from the treatment arm of the trial on the Attkisson and Greenfield (1994) Satisfaction questionnaire-8.

Qualitative feedback was collected from the treatment groups after the final session using the Music Therapy Patient Satisfaction Questionnaire.

The graphs produced visually represent the domains of how the treatment met the patient's needs, their levels of satisfaction with the treatment, the quality of treatment, and how much they felt the treatment had helped. The results will be discussed by hypothesis in the forthcoming chapters.

Chapter 7 Results: Part 1 Demographics and Hypothesis 1

In the first section of this chapter, the researcher for this project will describe the demographics of the study population and the variables within the sample (7.1.1). Graphs and tables are provided so comparisons between the treatment and control groups can be seen. The components of standard care, as received within the multi-disciplinary approach to both the treatment and control arms of the study, are tabulated (7.2). The intensity of these interventions is calculated in terms of hours of contact. The variables of age, length of stay, and offending history are explored for possible correlations with the treatment effect.

7.1 Introduction - demographics

VARIABLES		GROUPS	
		Control (n=6)	Therapy (n=9)
DOB Age	Mean=39.60, SD=11.14, median=34 , range=23-59	Mean39, SD=14.79, range=23-59	Mean=40, SD=8.94, range=29-50
	Median or above	2	6
	Below median	4	3
Ethnicity	<i>White British</i>	5	7
	<i>White Other</i>	-	1
	<i>African Black</i>	-	1
	<i>Caribbean Black</i>	1	-
Incarceration (since DOA)	M=6.12, SD=4.68, median=4.75 , range=1-16	M=5.33, SD=3.84	M=6.64, SD=5.32
	Median or above	2	6
	Below median	4	3
Index Offence	<i>Murder</i>	2	3
	<i>Manslaughter</i>	-	3
	<i>Bodily Harm</i>	3	-
	<i>Sexual Assault</i>	1	1
	<i>Arson</i>	-	1
	<i>Attempt Murder</i>	-	1
Mental Disorder	<i>Schizophrenia</i>	4	8
	<i>Comorb. Personality Disorder</i>	1	1
	<i>Other</i>	1	0
Offending History	M=15.5, SD=10.25, median=14 , range=1-39	M=15.5, SD=12.14, range=4-39	M=15.4, SD=9.57, range=1-34
	Median or above	3	6
	Below median	3	3

Table 7.1: Demographics by Treatment and Control Group.

7.1.1 Age

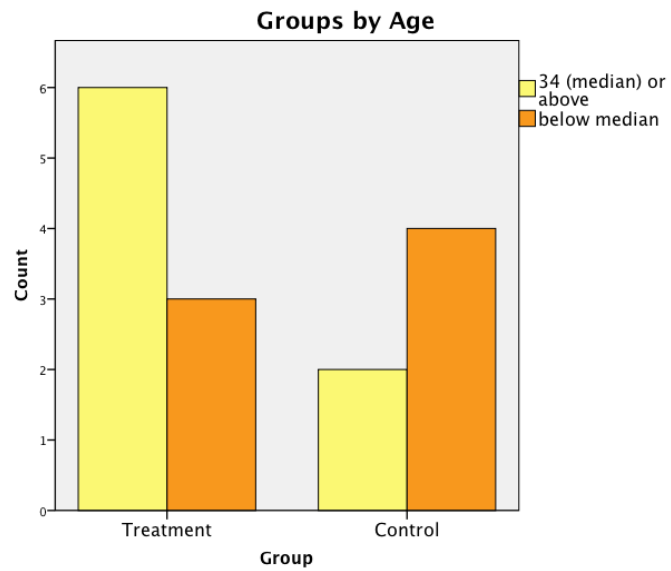


Figure 7.1: Groups by Age.

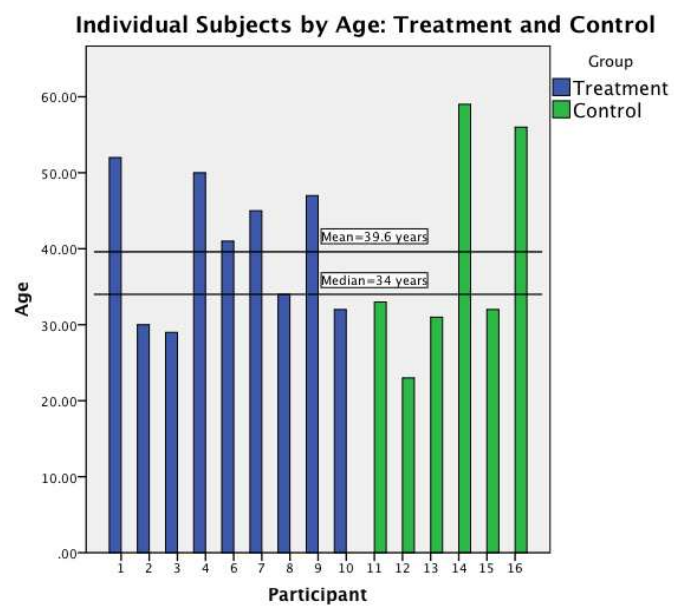


Figure 7.2: Individual participants by Group and Age above and below the median.

The demographics table (Table 7.1) shows that the age across both arms of the trial ranged from 23 years to 59 years old. There was a wider range in the control arm, however, with six of the nine patients above the median age for the combined sample of 34 years, the treatment arm are an older group, generally. Four of the six members of the control arm are below the age of 34 years.

7.1.2 Ethnicity

Eighty percent of the patients in the study were White British and 20% were+ from ethnic minority groups. The 2011 UK census reported 87.1% of the general population was of White ethnicity, 12.9% black and ethnic minorities. Leese (2006) reported that ethnic minority groups were over-represented in the high-secure hospital population. The population in this study at recruitment reflected these findings.

7.1.3 Length of Stay

Butwell and Jamieson (2000) conducted a retrospective study of all resident patients in a high-secure hospital in the UK by examining case registers and hospital records over a period of 10 years. They reported that the median length of stay for patients discharged at any time during the study was 6.3 years (mean 8.2 years, range 0.01-52.3).

The mean length of stay for the entire sample was 6.12 years .The median was 4.75 years. The mean length of stay since the date of admission in the treatment arm was 6.64 years and in the control arm 5.33 years, thus the two arms of the study were not matched. Since the participants in the control arm were on average younger than those in the treatment arm, their duration of stay was likely to have been shorter.

Figure 7.3 shows that six participants in the treatment arm were above the median length of stay of 4.75 years (maroon) and three were below (orange). Two patients in the control group were long-stay and four were short-stay, having stayed less than 4.75 years.

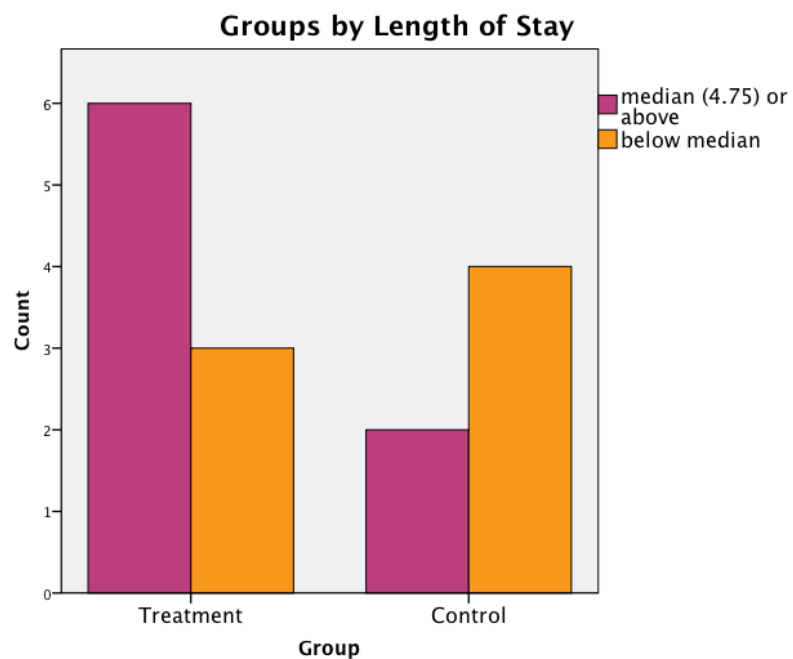


Figure 7.3: Groups by length of stay.

Figure 7.4 shows that there were at least two long-stay patients in the treatment group and two patients who had been admitted within the previous 18 months. This graph excludes one patient (T5), who dropped out after one session.

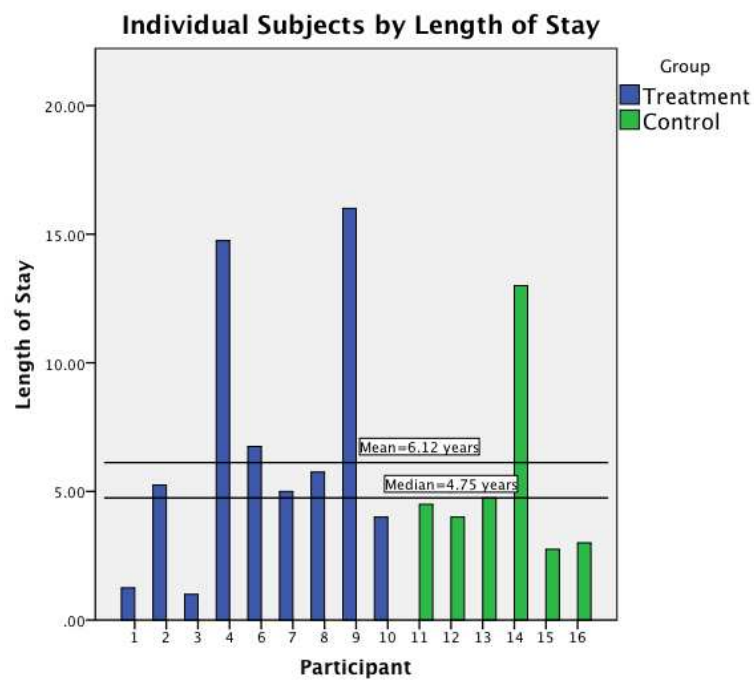


Figure 7.4: Individual participants by Group and Length of Stay.

Since the treatment and control arms could not be equally matched, consideration was given to the overall duration of offending history and how this may have impacted treatability.

7.1.5 Offending history

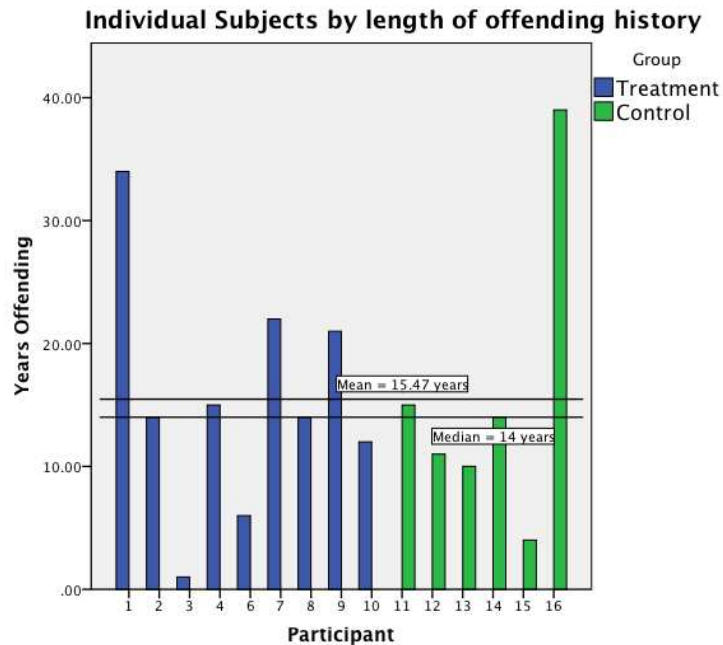


Figure 7.5: Individual participants by Group and Offending History.

Six of the nine patients in the treatment group had an offending history of the median of 14 years or above, whereas the participants in the control group were equally divided, with three above and three below the median. The overall mean of offending history for the sample was 15.4 years (Fig. 7.5).

7.1.5 Index Offence

The percentage of the treatment arm participants who had committed the most severe offence of having killed someone was 67% (n=6) and in the control group, 33% (n=2). Sleight and Compton (2013) described the risk of treating men who have killed as their behaviours mirroring their offence, and as such, their responses are frequently more extreme than of those who have not killed anyone.

7.1.6 Diagnosis

All participant patients had suffered psychotic symptoms, with 12 having had a formal diagnosis of schizophrenia, and one patient in each arm diagnosed with comorbid psychopathy. One patient in the control arm had a diagnosis of post-traumatic stress disorder (PTSD).

7.2 Standard Care

Standard Multi-Disciplinary Care was measured across both groups. The treatment group received recreational music, with a mean of 10 hours (SD = 16.91, Range = 0-40 hours), whereas the control group received a mean of 15 hours (SD = 23.28, Range = 0-52 hours).

Table 7.2 shows the components of standard care in the treatment and the control groups. The control group received a mean of 41 hours of psychology interventions, with only one participant not receiving any psychology, whereas in the treatment group, only four participants received psychology (mean = 10 hours). Thus the control group, within their overall MDT treatment, had the opportunity to develop more psychological awareness. Similarly, the control group received more physical activity and more recreational music, the combination of which had the potential to promote energetic mind-to-body integration.

Table 7.2: Standard Care from assessment to Follow-up (Total 27 WEEKS)

<i>Standard Care: August 2011 – February 2012 Total 27 WEEKS Assessment to Follow-up</i>			
	Treatment Group	Control Group (n=6)	<i>Overall</i>
Psychology	Mean = 10 hours SD = 23.65 Range = 0-72 hours (5 <i>not</i> receiving psychology)	Mean = 41 hours SD = 32.14 Range = 0-72 hours (1 <i>not</i> receiving psychology)	Mean = 22 hours SD = 30.51 Range = 0-72 hours
Physical Activities	Mean = 21 hours SD = 31.79 Range = 0-81 hours (4 doing sports)	Mean = 59 hours SD = 45.445 Range = 0-102 hours (5 doing sports)	, Mean = 36 hours, SD = 10.57, Range= 0-102 hours
Music	Mean = 10 hours SD = 16.91 Range = 0-40 hours (3 doing music)	Mean = 15 hours SD = 23.28 Range = 0-52 hours (2 doing music)	Mean = 12 hours SD = 19.04 Range = 0-52 hours
Other Activities	Mean = 98 hours SD = 58.16 Range = 50-232 hours (everyone)	Mean = 59 hours SD = 49.44 Range = 7-145 hours everyone)	Mean = 83 hours SD = 56.60 Range = 7-232 hours
Off-ward Day Centre Activities	Mean = 34 hours SD = 27.56 Range = 0-79 hours (4 doing CDU-RM)	Mean = 29 hours SD = 22.54 Range = 0-57 hours (5 doing CDU-RM)	Mean = 32 hours SD = 24.92 Range = 0-79 hours

7.3. The Primary Outcome measure PROQ2

In this section, the researcher for this project provides an overview of the findings solely in relation to the primary hypothesis (H1 relating to others (5.4.)), as shown by the primary outcome measure in Table 7.3. The descriptive statistics are presented as tables and in Appendix 4c as bar charts. These are interpreted in terms of statistical significance and trends across time and between groups.

Treatment effects in each of the domains of the PROQ2 are then compared with the mean of the treatment and the mean of the control group. The researcher then examined them for possible correlations with the variables of age (7.3.4), length of stay (7.3.5), and duration of offending history (7.3.6).

Following a detailed examination of the primary outcome measure, the statistical analysis of the secondary measure: the Multi-scale Dissociation Inventory (MDI) (7.4)) was then considered in the domain of disengagement because this domain may provide further evidence about whether or not relational changes to others have occurred (H1).

In section 7.5, the researcher shows the tabulated statistical results of the observational measure: The Chart for Interpersonal Relating in Closed Living Environments (CIRCLE). The separate domains of sociable, friendly, hostile, and withdrawn are presented to show changes across time and across groups. Treatment effects between groups, as demonstrated on the CIRCLE, are examined for correlations with age, length of stay, and duration of offending.

In section 7.6, the researcher presents the main qualitative themes relevant to H1 as drawn from the Interpretative Phenomenological Analysis (IPA) of the semi-structured interviews of music therapists' observations and experiences (stage 5 IPA analysis). The researcher then triangulated them against the positive qualities of the PROQ2, which were relevant to H1, as shown in Tables 7.16 and 7.17. The domains of particular relevance were called Neutral Distant (ND) and Neutral Close (NC).

Table 7.18 shows the results of this triangulation exercise in which the themes were separated into musical and verbal themes. The researcher then further triangulated them with the SPSS statistical results, to provide further evidence in support of H1.

Hypothesis 1 (H1) Relating to Others

Musical improvisation delivered to men who had committed violent offences and who were receiving secure hospital treatment including manualised Group Cognitive Analytic Music Therapy (G-CAMT), would improve their relating to others, as compared with the control group, who received standard multi-disciplinary treatment as usual, as measured by the PROQ2 (Birtchnell and Evans 2004) and the manual for CIRCLE (Blackburn and Glasgow 2006).

7.3.1 Descriptive Statistics

The researcher for this project entered the raw data into SPSS software; histograms showed that distribution was not normal. The Mann-Whitney test was performed on the outcome measures because after attrition the two arms of the trial were no longer matched thus there were outliers, The Mann Whitney test compared mean ranks between the treatment (T) and control (C) groups at each time point. This is sometimes seen as comparing medians, although this is not strictly the case. Separate tests were undertaken at each time point. Time point 2 was eliminated after an initial analysis because the data were incomplete and it was not possible to collect them at an exact mid-point.

Table 7.3 shows statistically significant improvement *between* the treatment and control groups in the UD domain post-treatment in favour of the intervention. Table 7.3 also shows significant differences in favour of the intervention *within* the treatment group in both the UC and the ND domains across time

Secondly, the researcher used Friedman's test to check for differences within groups across time taking the baseline and the follow-up scores only. This meant conducting two separate tests: one for the treatment group and one for the control group.

Table 7.4a shows significant change in favour of the treatment group in the UC domain ($p=.007$) and significant change in the treatment group in the NC domain ($p=.042$), but in favour of the control group in the ND domain ($p=.044$).

Table 7.3: Negative and positive qualities of PROQ2 domains by treatment and control across time, and between groups
(Blue asterisks indicate significant difference between groups and green indicates significant difference across time.)

PROQ2 Octants Negative Qualities		Time 1: Pre-treatment		Time 3: Post-treatment		Time 4: Follow-up		PROQ2 Octants Positive Qualities
		T (n=9)	C (n=6)	T (n=9)	C (n=6)	T (n=9)	C (n=6)	
UN pompous, boastful, dominating, insulting	Mean (SD) median	19.67 (4.69) 19	19.83 (4.96) 19	19.56 (5.05) 20	16.50 (6.98) 16.50	19.00 (5.70) 20	17.00 (4.69) 17	Leading, guiding, advising
UC intrusive, restrictive, possessive	Mean (SD) median	15.44 (7.02) 17**	12.17 (5.38) 10	13.33 (7.31) 12**	12.50 (5.47) 12.50	10.56 (6.86) 11**	9.67 (4.97) 9	Protecting, helping, providing for
NC fear of separation and of being alone	Mean (SD) median	23.22 (4.92) 24	20.17 (6.70) 18.50	22.67 (4.36) 22	20.00 (5.10) 20	19.78 (7.24) 21	19.83 (6.18) 20	Friendly involvement and interest
LC Fear of rejection and disapproval	Mean (SD) median	22.78 (3.67) 23	21.00 (4.98) 21.50	21.67 (4.85) 23	20.17 (7.36) 21.50	23.00 (4.18) 24	21.50 (3.27) 21.50	Seeking care and control
LN helpless shunning responsibility self-denigrating	Mean (SD) median	20.33 (7.23) 23**	16.17 (8.08) 20	16.67 (6.98) 20**	16.83 (7.57) 19.50	16.78 (6.28) 19**	16.67 (7.15) 19.50	Seeking direction, guidance and advice

LD acquiescent, subservient, withdrawn	Mean (SD) median	20.89 (6.99) 22	16.33 (8.87) 18.50	19.56 (7.40) 23	18.83 (9.15) 21	18.56 (7.16) 18	19.00 (6.99) 19	Obedient, loyal and respectful
ND suspicious, uncommunicative, self-reliant	Mean (SD) median	12.66 (6.32) 12*	16.00 (7.16) 15	16.44 (5.41) 17*	12.17 (3.31) 14	16.00 (6.56) 16*	11.17 (7.05) 11	Needing personal space and privacy
UD sadistic, intimidating, tyrannizing	Mean (SD) median	20 (4.33) 20	18.16 (2.32) 18	21.11 (4.28) 23*	15.83 (4.26) 17.50*	19.77 (4.97) 19	17.50 (3.73) 16.50	Controlling and maintaining order

Sig. difference between groups at $p < .05$, * sig. difference within groups at $p < .05$, ** $p < .01$

Table 7.4a: Significant and nearly significant changes (Friedman test) in PROQ2 domains between pre-treatment and follow-up.
(Improvement in green, deterioration in red.)

PROQ2 Octants	Treatment (n=9)				Control (n=6)		
		Pre-Treatment	Follow-Up	<i>p-values</i>	Pre-Treatment	Follow-Up	<i>p-values</i>
UN	Mean (SD) median	19.67 (4.69) 19	19.00 (5.70) 20	<i>Non-sig.</i>	19.83 (4.96) 19	17.00 (4.69) 17	<i>p= .058</i>
UC	Mean (SD) median	15.44 (7.02) 17	10.56 (6.86) 11	<i>p= .007**</i>	12.17 (5.38) 10	9.67 (4.97) 9	<i>Non-sig.</i>
NC	Mean (SD) median	23.22 (4.92) 24	19.78 (7.24) 21	<i>p= .042*</i>	20.17 (6.70) 18.50	19.83 (6.18) 20	<i>Non-sig.</i>
LN	Mean (SD) median	20.33 (7.23) 23	16.78 (6.28) 19	<i>P= .027*</i>	16.17 (8.08) 20	16.67 (7.15) 19.50	<i>Non-sig.</i>
ND	Mean (SD) median	12.66 (6.32) 12	16.00 (7.16) 15	<i>p= .044*</i>	16.00 (6.56) 16	11.17 (7.05) 11	<i>p= .058</i>

Table 7.4b: Descriptive statistics of PROQ2 domains with treatment effects between pre-treatment and follow-up by treatment and control.

PROQ2 Octants		Treatment (n=9)			Control (n=6)		
		Pre-Treatment	Follow-Up	<i>Difference</i>	Pre-Treatment	Follow-Up	<i>Difference</i>
UN	Mean	19.67	19.00	-0.67	19.83	17.00	-2.83
	(SD)	(4.69)	(5.70)	(3.12)	(4.96)	(4.69)	(3.19)
	median	19	20	-1	19	17	-2
UC	Mean	15.44	10.56	-4.89	12.17	9.67	-2.50
	(SD)	(7.02)	(6.86)	(2.42)	(5.38)	(4.97)	(3.45)
	median	17	11	-4	10	9	-2.50
NC	Mean	23.22	19.78	-3.44	20.17	19.83	-0.33
	(SD)	(4.92)	(7.24)	(4.36)	(6.70)	(6.18)	(2.42)
	median	24	21	-2	18.50	20	-0.50
LC	Mean	22.78	23.00	0.22	21.00	21.50	0.50
	(SD)	(3.67)	(4.18)	(3.46)	(4.98)	(3.27)	(4.28)
	median	23	24	0	21.50	21.50	0.50
LN	Mean	20.33	16.78	-3.56	16.17	16.67	0.50
	(SD)	(7.23)	(6.28)	(4.13)	(8.08)	(7.15)	(6.60)
	median	23	19	-2	20	19.50	0.50

LD	Mean (SD) median	20.89 (6.99) 22	18.56 (7.16) 18	-2.33 (4.27) -2	16.33 (8.87) 18.50	19.00 (6.99) 19	2.67 (4.08) 2.50
ND	Mean (SD) median	12.66 (6.32) 12	16.00 (7.16) 15	3.33 (4.15) 4	16.00 (6.56) 16	11.17 (7.05) 11	-4.83 (5.74) -2.50
UD	Mean (SD) median	20 (4.33) 20	19.77 (4.97) 19	-0.22 (4.24) -1	18.16 (2.32) 18	17.50 (3.73) 16.50	-0.67 (4.76) -1

7.3.2 The PROQ2 Domains

The bar charts (Appendix 4c, Figures A4c.i-vi) show the treatment group as a whole in blue and the control group in green. Each group is represented at baseline pre-treatment, post-treatment, and follow-up. Figures 6.2 and 6.3 provide a visual description of the positive and negative qualities of the PROQ2 domains for cross reference to the following descriptions.

PROQ2 Domains:

- 1. Upper Neutral (UN):** This domain measures pompous, boastful, dominating, and insulting as negative qualities, and leading, guiding, and advising as positive qualities. The mean scores across time in the treatment group indicated a slight trend of improvement; the median is shown in Tables 8 and 9. Having controlled for outliers, the median indicates a minor deterioration in the treatment group, which may actually be indicative of the treatment group's participants' abilities to express themselves more freely in the positive aspects of this domain by sharing in the musical experience, advising, guiding, and leading each other (see Appendix 4c, Fig. A4c.i). The positive qualities of this domain also refer as much to the qualities required of the music therapist as to those of the patients. The researcher explored these qualities in the qualitative analysis. The researcher also examined the strength of correlations between patient experiences and music therapists' observations and experiences against these results to further explore the possibility of Type 1 or 2 errors or to further validate this interpretation (score range: 0-30).
- 2. Upper Close (UC)**** This domain measures restrictive, intrusive and possessive behaviour as negative qualities. This statistically significant result $p < 0.01$ in favour of the treatment group shows improvement in the positive UC qualities of protecting, helping and providing for others (see Appendix 4c, Fig. A4c.ii0). The mean score demonstrates that the treatment group improvement across time was sustained at follow-up. There is no statistically significant change in the control group. The triangulated IPA data further supports these findings with evidence of the positive qualities of UC.
- 3. Neutral Close (NC)** This domain measures fear of separation and of being alone as negative qualities, and more friendly involvement and interest as positive qualities. The treatment group improved significantly across time to follow up, $p = .042$ ($p < .05$) when measured at pre-treatment and at follow-up (see Appendix 4c, Fig. A4c.iii). The median scores indicate that the control group are not connecting with others and have greater fear of separation and of being alone. The positive improvement in the treatment group, whilst not statistically significant is supported by the qualitative analysis, which demonstrates friendly involvement and interest.

4. Lower distant (LD) This domain measures acquiescent, subservient, withdrawn responses as negative qualities, and obedient, loyal and respectful responses as positive qualities. The control group deteriorated from pre-test baseline to follow-up.

A small but positive change in the treatment group is too small to attribute to the intervention (Independent variable) across time to follow-up (see Appendix 4c, Fig. A4c.iv). The interpretation of this trend however is that the group analytic effect of sociability may have had some effect in the treatment group, despite the time-limit constraint.

5. Neutral Distant (ND)* This domain measures suspicious, uncommunicative and self-reliant behaviours as negative qualities. The positive qualities on the outcome measure refer to a healthy need for personal space and privacy.

The intervention (independent variable: jointly- created music in a group) is not designed to promote the need for personal space and privacy.

Not unexpectedly therefore the treatment group show a statistically significant result against treatment effect across time from baseline to follow-up as shown by the Friedman test $p=.044$ ($p<.05$) Whereas the control group show improvement $p=.058$ (Table 9, Appendix 4c, Fig. A4c.v).

However, since the intervention is designed to promote relatedness through the group-work processes, the clinical implication is that the treatment group, having effectively survived the time-limited ending as a shared experience, may have developed greater self-reliance as a positive attribute.

6. Upper distant (UD)* This domain measures sadistic, intimidating, tyrannizing responses as negative qualities, and controlling and maintaining order as positives. These negative attributes correspond to offence-related behaviours, which led to incarceration for the safety of the general public. Table 8 shows that the scores of the treatment group are all higher at baseline than the control group, so they are a more sadistic, intimidating and tyrannizing group as a whole. The demographics (7.1) also demonstrate this fact as six of the nine treatment participants had killed, plus one had attempted to murder, leaving only two who had not killed. Some of them had killed more than once. This compared with two of the six control group participants who had killed.

In the (UD) domain there was statistical significance as measured with the Mann-Whitney test between groups at post-treatment with the treatment group apparently worse. However, by follow-up the treatment group median score trend was of improvement from baseline (see Appendix 4c, Fig. A4c.vi).

7.3.3 Overview of treatment effects for domains of PROQ2

Table 7.5: Participants above and below the median by groups and age/ length of stay/ offending history.

		Groups	
		Treatment (n=9)	Control (n=6)
Age (median=34y)	Below median	3	4
	Median or above	6	2
Length of Stay (median=4.75y)	Below median	3	4
	Median or above	6	2
Offending History (median=14y)	Below median	3	3
	Median or above	6	3

The mean treatment effects by group in the PROQ2 domains and in the CIRCLE observational outcome measure were compared with variables of age, length of stay and duration of offending history. These three variables were computed by using the median of each as a cut-off, i.e. subjects either fell below the median or above it. Tables 7.6a – 7.8b examine trends of change and statistically significant correlations with the age, length of stay and duration of offending history with treatment effect in each domain.

7.3.4 Treatment Effects by Group and Age

Table 7.6a: Participants below the median age of 34 years in treatment and control.

PROQ2 Octants		Treatment (n=3)			Control (n=4)		
		Pre-Treatment	Follow-Up	<i>Difference</i>	Pre-Treatment	Follow-Up	<i>Difference</i>
UN	Mean	21.67	21.33	-0.33	22.00	17.75	-4.25
	(SD)	(5.51)	(4.16)	(2.08)	(4.24)	(5.12)	(2.87)
	median	19	20	-1	22.50	18	-3.50
UC	Mean	17	12.67	-4.33	14.25	10.00	-4.25
	(SD)	(2.65)	(2.89)	(2.31)	(5.56)	(6.32)	(2.63)
	median	18	11	-3	14	9	-3.50
NC	Mean	23.00	21.33	-1.67	19.75	18.25	-1.50
	(SD)	(2.65)	(2.52)	(2.08)	(7.59)	(6.90)	(1.29)
	median	24	21	-1	18.50	17.50	-1.50
LD	Mean	18.00	14.67	-3.33	17.75	21.00	3.25
	(SD)	(9.85)	(8.62)	(5.69)	(7.93)	(4.76)	(4.99)
	median	15	13	-5	18.50	19	2.50
ND	Mean	11.33	14.67	3.33	16.75	10.50	-6.25
	(SD)	(5.13)	(3.79)	(7.37)	(5.91)	(6.61)	(6.80)
	median	10	13	6	15	11	-6.50
UD	Mean	22.00	20.67	-1.33	19.25	17.50	-1.75
	(SD)	(5.00)	(4.73)	(1.53)	(1.89)	(3.87)	(5.38)
	median	22	19	-1	18.50	16.50	-2

Table 7.6b: Participants at or above the median age of 34 years in treatment and control

PROQ2 Octants		Treatment (n=6)			Control (n=2)		
		Pre-Treatment	Follow-Up	<i>Difference</i>	Pre-Treatment	Follow-Up	<i>Difference</i>
UN	Mean	18.67	17.83	-0.83	15.50	15.50	0.00
	(SD)	(4.41)	(6.34)	(3.71)	(3.54)	(4.95)	(1.41)
	median	19	20	-1	15	15.50	0
UC	Mean	14.67	9.50	-5.17	8.00	9.00	1.00
	(SD)	(8.59)	(8.24)	(2.64)	(1.41)	(1.41)	(1.41)
	median	15	8.50	-4	8	9	1
NC	Mean	23.33	19.00	-4.33	21.00	23.00	2.00
	(SD)	(5.99)	(8.90)	(5.09)	(7.07)	(4.24)	(2.83)
	median	24.50	21.50	-3.50	21	23	2
LD	Mean	22.33	20.50	-1.83	13.50	15.00	1.50
	(SD)	(5.65)	(6.22)	(3.92)	(13.44)	(11.31)	(2.12)
	median	23.50	19	-1	13.50	15	1.50
ND	Mean	13.33	16.67	3.33	14.50	12.50	-2.00
	(SD)	(7.20)	(7.84)	(2.42)	(12.02)	(10.61)	(1.41)
	median	12	17.50	3	14.50	12.50	-2
UD	Mean	19.00	19.33	0.33	16.00	17.50	1.50
	(SD)	(4.05)	(5.47)	(5.16)	(1.41)	(4.95)	(3.54)
	median	19	19.50	-1.50	16	17.50	1.50

Table 7.6a and 7.6b show that all patients in the treatment group regardless of age improved in the LD domain compared with the control group who got worse. This suggests that the treatment group became more able to express themselves with respectfulness and loyalty to others and obedience to group rules, rather than withdrawing in an acquiescent and subservient manner. This also suggests that the treatment group became more able to choose for themselves. The control group regardless of age became more acquiescent, subservient and withdrawn.

Table 7.6b shows that the 'Upper Close' negative qualities of intrusive, restrictive and possessive behaviour were reduced with most effect across the duration of the treatment in the older members of the treatment group, whilst those in the control group above the median age deteriorated. All subjects below the median age demonstrated improvement (Table 7.6a), which suggests greater capacity for change in the younger subjects generally but this cannot be attributed to the intervention. However for those above the median of which there are 6 patients in the treatment group compared to 2 in the control group, G-CAMT helped older, more treatment resistant patients to become less intrusive, restrictive or possessive. (mean difference -5.17 median -4. compared with deterioration in control of 1.00) median 1. 0).

The NC domain shows that there was a treatment effect with a reduction of the fear of separation and being alone in the treatment arm, with greater effect in older patients. The implication being that the positive qualities of more friendly involvement and interest developed in the older patients in the treatment group. Whereas the older patients in the control group deteriorated. The positive attributes of the ND domain are the need for personal space and privacy, of which the negative qualities, (which are those which are measured on PROQ2 analysis) are to be suspicious, uncommunicative and self-reliant. Whether this is a reliable measure of neutral distant qualities and for unknown reasons the control group below the median age of 34 years show the greatest need for personal space and are not engaging with others, but are more withdrawn.

7.3.5 Treatment Effects by Group and Length of Stay

Table 7.7a: Participants below the median length of stay 4.75 years by treatment and control.

PROQ2 Octants		Treatment (n=3)			Control (n=4)		
		Pre-treatment	Follow-Up	Difference	Pre-Treatment	Follow-Up	Difference
UN	Mean	17.67	19.67	2.00	18.75	15.50	-3.25
	(SD)	(1.53)	(1.53)	(2.37)	(5.06)	(5.20)	(3.20)
	median	18	20	2	18.50	13.50	-2
UC	Mean	21.33	17.00	-4.33	12.25	9.00	-3.25
	(SD)	(4.93)	(6.56)	(2.31)	(6.13)	(6.22)	(3.40)
	median	19	16	-3	10	7	-2.50
NC	Mean	24.67	21.33	-3.33	21.25	19.75	-1.50
	(SD)	(4.51)	(2.52)	(2.08)	(8.22)	(7.97)	(1.29)
	median	25	21	-4	21.50	20.50	-1.50
LD	Mean	17.00	17.00	0.00	15.00	18.25	3.25
	(SD)	(10.44)	(6.08)	(4.36)	(10.65)	(8.66)	(4.99)
	median	12	14	2	15	19	2.50
ND	Mean	8.67	9.33	0.67	14.00	7.25	-6.75
	(SD)	(7.64)	(5.51)	(5.51)	(7.96)	(4.57)	(6.13)
	median	7	12	1	12.50	7.50	-6.50
UD	Mean	19.00	18.67	-0.33	18.50	15.25	-3.25
	(SD)	(2.65)	(1.53)	(2.52)	(2.89)	(1.50)	(3.30)
	median	18	19	0	18.50	15	-2

Table 7.7b: Participants at or above median length of stay 4.75 years and control

PROQ2 Octants		Treatment (n=6)			Control (n=2) (C3&4)		
		Pre-Treatment	Follow-Up	<i>Difference</i>	Pre-Treatment	Follow-Up	<i>Difference</i>
UN	Mean	20.67	18.67	-2.00	22.00	20.00	-2.00
	(SD)	(5.54)	(7.12)	(2.37)	(5.66)	(1.41)	(4.24)
	median	20	20	-1.50	22	20	-2
UC	Mean	12.50	7.33	-5.17	12.00	11.00	-1.00
	(SD)	(6.16)	(4.55)	(2.64)	(5.66)	(1.41)	(4.24)
	median	13.50	8.50	-4	12	11	-1
NC	Mean	22.50	19.00	-3.50	18.00	20.00	2.00
	(SD)	(5.36)	(8.90)	(5.36)	(2.83)	(2.83)	(2.83)
	median	22.50	21.50	-1.50	18	20	2
LD	Mean	22.83	19.33	-3.50	19.00	20.50	1.50
	(SD)	(4.58)	(8.07)	(4.09)	(5.66)	(3.54)	(2.12)
	median	23.50	19	-4	19	20.50	1.50
ND	Mean	14.66	19.33	4.67	20.00	19.00	-1.00
	(SD)	(5.13)	(4.08)	(3.01)	(4.24)	(1.41)	(2.83)
	median	12	19	4.50	20	19	-1
UD	Mean	20.50	20.33	-0.17	17.50	22.00	4.50
	(SD)	(5.13)	(6.12)	(5.12)	(0.71)	(1.41)	(0.71)
	median	20.50	20	-1.50	17.50	22	4.50

In the UC domain long-stay patients who received G-CAMT improve as do short-stay patients, compared with minimal improvement in the long-stay patients in the control group, thus G-CAMT may have greater effect in long stay patients compared to the control group. All participants below the median length of stay improved in this domain therefore length of stay did not correlate with changes in the younger patients in this domain (Table 7.7a and 7.7b).

The NC domain shows that improvement occurred in all those in the treatment group regardless of length of stay in the high secure treatment setting. This has a positive implication for the effect of G-CAMT on institutionalised patients when compared with the control group in which those above the median length of stay (4.75 years) deteriorated.

The above median treatment group participants, those who had been incarcerated for longer, at baseline show greater fear of separation and of being alone (mean 22.50) compared with the control group (mean 18.00), compared to the mean treatment effect in the treatment group which indicates an improved score by a (mean -3.50) demonstrating less fear of separation and being alone and inferring greater friendly involvement and interest despite the length of stay, and compared with the control group who deteriorated (mean 2.0).

In the LD domain the control group have all become more acquiescent and withdrawn regardless of length of stay. There is no change in shorter stay treatment subjects; however those in treatment above the median show marked improvement, compared to control subjects who deteriorated, thus suggesting a treatment effect attributable to G-CAMT for those above the median length of stay with improvement in the qualities of loyalty and respectful obedience.

Table 7.7b ND domain shows that patients in the control group who have been resident in high secure treatment for less than the median length of stay have a need for personal space and privacy, which is unrelated to the intervention.

7.3.6 Treatment Effects by Group and Duration of Offending

Table 7.8a: Participants with offending history below median 14 years by treatment and control.

PROQ2 Octants		Treatment (n=3)			Control (n=3)		
		Pre-Treatment	Follow-Up	<i>Difference</i>	Pre-Treatment	Follow-Up	<i>Difference</i>
UN	Mean	19.33	19.33	0.00	23.67	18.67	-5.00
	(SD)	(1.53)	(1.15)	(1.73)	(3.21)	(5.86)	(3.00)
	median	19	20	-1	25	21	-5
UC	Mean	15.00	10.33	-4.67	16.33	11.33	-5.00
	(SD)	(6.08)	(6.03)	(2.08)	(4.51)	(7.02)	(2.65)
	median	18	11	-4	16	12	-4
NC	Mean	22.00	21.00	-1.00	22.33	20.67	-1.67
	(SD)	(2.65)	(2.00)	(3.00)	(6.81)	(6.03)	(1.53)
	median	21	21	-1	20	20	-2
LD	Mean	22.00	21.33	-0.67	21.00	22.00	1.00
	(SD)	(10.44)	(7.37)	(4.04)	(5.57)	(5.29)	(2.65)
	median	27	24	0	22	20	2
ND	Mean	12.00	13.00	1.00	18.33	10.67	-7.67
	(SD)	(5.00)	(1.00)	(5.57)	(6.11)	(8.08)	(7.57)
	median	12	13	2	17	12	-11
UD	Mean	19.67	18.33	-1.33	19.67	17.67	-2.00
	(SD)	(2.52)	(1.15)	(1.53)	(2.08)	(4.73)	(6.56)
	median	20	19	-1	19	16	-3

Table 7.8b: Participants with offending history at or above median 14 years by treatment and control.

PROQ2 Octants		Treatment (n=6)			Control (n=3)		
		Pre-Treatment	Follow-Up	<i>Difference</i>	Pre-Treatment	Follow-Up	<i>Difference</i>
UN	Mean	19.83	18.83	-1.00	16.00	15.33	-0.67
	(SD)	(5.85)	(7.17)	(3.74)	(2.65)	(3.51)	(1.53)
	median	19	20.50	-1.50	17	15	-1
UC	Mean	15.67	10.67	-5.00	8.00	8.00	0.00
	(SD)	(7.99)	(7.79)	(2.76)	(2.00)	(2.00)	(2.00)
	median	15.50	10	-3.50	8	8	0
NC	Mean	23.83	19.17	-4.67	18.00	19.00	1.00
	(SD)	(5.88)	(9.00)	(4.63)	(7.21)	(7.55)	(2.65)
	median	26	22	-3.50	16	20	0
LD	Mean	20.33	17.17	-3.17	11.67	16.00	4.33
	(SD)	(5.79)	(7.31)	(4.49)	(10.02)	(8.19)	(5.13)
	median	21.50	16.50	-4	8	18	3
ND	Mean	13.00	17.50	4.50	13.67	11.67	-2.00
	(SD)	(7.32)	(7.77)	(3.21)	(8.62)	(7.64)	(1.00)
	median	12	19	4.50	12	10	-2
UD	Mean	20.17	20.50	0.33	16.67	17.33	0.67
	(SD)	(5.23)	(6.09)	(5.16)	(1.53)	(3.51)	(2.89)
	median	19.50	20.50	1.50	17	17	-1

In the UC domain: the treatment effect in terms of a reduction of intrusive, restrictive and possessive behaviour when examined against the duration of offending history shows the most improvement in favour of the treatment group for participants who were above the median of 14 years of offending history (Table 7.8b) compared with the control group who deteriorated.

NC domain: The treatment effect of reduced fear of separation and being alone is improved in those receiving the intervention regardless of a long offending history this may be attributed to the intervention as the control group who fall above the median deteriorated in this respect (Table 7.8a and 7.8b)

In the LD domain the treatment effect in addressing withdrawn, acquiescent and subservient behaviour, showed that those who fell above the median of 14 years of offending history who received the intervention showed improvement, whereas those in the control group all deteriorated.

ND Domain: The treatment effect, the negative qualities of which are suspicious, uncommunicative and self-reliant behaviour get worse in the treatment group compared to the control group who seek private space.

7.4 H1: Secondary Outcome measure MDI: domain disengagement

Table 7.9: Domain disengagement treatment and control across time

		Time 1: Pre-treatment		Time 3: Post-treatment		Time 4: Follow-up	
		T (n=9)	C (n=6)	T (n=9)	C (n=6)	T (n=9)	C (n=6)
DENG (Disengagement)	Mean	9.44	8.83	10.11	11.83	10.44	9.83
	(SD)	(3.71)	(1.83)	(4.26)	(3.06)	(5.55)	(2.23)
	median	8	8.50	8	11.50	8	10

Table 7.9 shows no change in the treatment arm in the domain of disengagement in the multi- scale dissociation inventory (MDI. In comparing the treatment and control arms this result may simply indicate stability in the treatment participants' levels of engagement compared with higher, therefore deteriorating scores in the control arm. Whilst there is no improvement across time in the treatment arm, neither is there any deterioration. This may suggest that dissociative traits may have been safely contained by the intervention within the safety of the therapeutic environment, and that this stability sustained at follow –up. The structure of G-CAMT is designed to reduce the risk of violence, which can erupt if the dissociative psychological defence operates (Compton Dickinson.2006, 2013). This result suggests that there are also implications for the levels of containment and the effect of mindfulness techniques which are provided by G-CAMT since the control arm apparently deteriorate which suggests that recreational or passive music listening / making may not have any effect in reducing dissociation because higher levels of dissociation indicate disengagement and a lack of mindfulness. This requires further investigation in a separate study.

7.4.1. Descriptive Statistics

The cut off for clinical concern for psychopathy in The Multi-Scale Dissociation Inventory (MDI is a score at or greater than 14 (score range 5-25) (Briere, 2002). Table 7.10 shows the high levels of treatment resistance in the treatment and control group by individual participants. This table (7.10) highlights individual scores across time in the one domain of disengagement. On further investigation by unmasking the diagnoses of the individual participants, this process confirmed that the treatment arm were weighted with more psychopathy and therefore they were treatment resistant. Patient T1, T7 and T10 are all long – stay patients above the median age with numerous offences, diagnosed with psychopathic disorder and mental illness. Their scores are above the clinical cut off point for psychopathy at pre-test and the higher follow-up scores suggest that these psychopathic patients are less able to internalize the therapy experiences than those who have a primary diagnosis of schizophrenia. This is probably due to the psychopathic ability to cut off completely by shifting to a

callous self- state if feeling abandoned, rather than developing an ability to internalise the therapeutic experience and the closure. The results in this domain of disengagement (7.9) however show that the control arm are more disengaged at the end of treatment; despite baseline measurements that indicate that they are more engaged at the start of the study (Table 7.9). Therefore despite the increased levels of psychopathy in the treatment arm, having controlled for these outliers, the median scores remained stable and can be considered as valid.

Whilst this table does not show statistically significant results, and it only refers to one domain of the MDI rather than a full analysis of all MDI domains, the direction of trend in this domain, which is relevant to changes in relating, supports the PROQ2 findings in the LD and NC domains. In which the treatment participants become less withdrawn and developed less fear of separation.

Table 7.10: MDI disengagement domain mean scores by individual participants in the treatment and control groups. (A reduced score demonstrates improvement.)

	Attendance	DENG 1 (Pre-Treatment)	DENG 3 (Post-Treatment)	DENG 4 (Follow-Up)
T1	81.25%	14	17	21
T2	100%	8	10	7
T3	100%	10	8	8
T4	81.25%	7	7	8
T6	100%	9	8	8
T7	93.75%	6	5	10
T8	100%	7	7	6
T9	31.25%	7	13	7
T10	87.5%	17	16	19
Total of clinical concern (n=9)		N=2 (22%)	N=2	N=2
C1		8	12	11
C2		11	11	8
C3		11	17	13
C4		7	13	11
C5		9	8	9
C6		7	10	7
Total of clinical concern (n=6)		N=0	N=1 (17%)	N=0

7.4.2 The MDI Domain

1. Disengagement The control group is more disengaged at the end of treatment despite at baseline being more engaged at start. This may indicate disgruntlement at not receiving the intervention (Appendix 4d, Fig. A4d.i) however the patient preference methodology sought to reduce this effect.

7.5 H1: Observational Rating: CIRCLE

The post treatment data collection of this measure was not immediate after the end of the treatment intervention; it was spasmodic due to staffing issues because the criteria for completing this questionnaire state that the nurse who does so, must have known the patient for at least one month (Blackburn and Glasgow, 2006).

7.5.1 Descriptive Statistics

Table 7.11 shows statistically significant difference between the Treatment and Control groups as measured by the Mann Whitney test in the hostile domain at baseline (marked by the blue asterisks**). The Mann-Whitney Test was run to test the difference in the domain of hostility at baseline between Treatment and Control: this shows a statistically significant difference between groups against the treatment group: $p=0.006$ who are more hostile.

The Friedman's Test was then run to test changes across time within each group across time points 1, 3 and 4 and there were no significant difference in any domains, however the trend of positive change in the treatment group in the hostile domain with a reduction in the median score at post treatment required further investigation. Both groups are equally scored with a median of 4. The Friedman's test was then run to measure change from baseline to follow-up.

Table 7.11: Descriptive statistics of CIRCLE domains by treatment and control across time.

** significant difference at $p < .01$ at baseline is marked in blue.

CIRCLE domains		Time 1: Pre-treatment		Time 3: Post-treatment		Time 4: Follow-up	
		T (n=8)	C (n=5)	T (n=8)	C (n=5)	T (n=8)	C (n=3)
Hostile	Mean (SD) median	6.50 (2.67) 7**	2.20 (1.10) 2**	5.50 (3.46) 6	3.60 (2.70) 2	4.50 (3.16) 4	5.00 (2.65) 4
Withdrawn	Mean (SD) median	7.75 (4.62) 8	6.80 (3.11) 7	7.00 (4.00) 8	7.00 (3.54) 8	7.88 (3.94) 9.50	8.33 (2.08) 9
Friendly	Mean (SD) median	10.00 (3.70) 9	13.40 (2.51) 13	10.88 (3.18) 10.50	9.20 (4.32) 10	11.88 (3.52) 12	10.67 (2.89) 9
Sociable	Mean (SD) median	7.25 (2.71) 7	8.40 (3.29) 8	8.50 (3.59) 8	9.00 (2.58) 9	8.88 (4.05) 9.50	7.33 (1.53) 7

Table 7.12: Descriptive statistics of CIRCLE domains with treatment effects between pre-treatment and follow-up by treatment and control. [Reduction of hostility in the treatment group and increased hostility in the control group. The control group became more withdrawn and less friendly (shown in red deterioration).] green indicates improvement.

CIRCLE domains		Treatment (n=8)			Control (n=5)		
		Pre-Treatment	Post-Treatment	<i>Difference</i>	Pre-Treatment	Post-Treatment	<i>Difference</i>
Hostile	Mean	6.50	5.50	<i>-1.00</i>	2.20	3.60	<i>1.40</i>
	(SD)	(2.67)	(3.46)	<i>(3.16)</i>	(1.10)	(2.70)	<i>(3.21)</i>
	median	7	6	<i>-2.50</i>	2	2	<i>1</i>
Withdrawn	Mean	7.75	7.00	<i>-0.75</i>	6.80	7.00	<i>0.20</i>
	(SD)	(4.62)	(4.00)	<i>(2.12)</i>	(3.11)	(3.54)	<i>(3.03)</i>
	median	8	8	<i>-1</i>	7	8	<i>2</i>
Friendly	Mean	10.00	10.88	<i>0.88</i>	13.40	9.20	<i>-4.20</i>
	(SD)	(3.70)	(3.18)	<i>(3.52)</i>	(2.51)	(4.32)	<i>(6.53)</i>
	median	9	10.50	<i>1.50</i>	13	10	<i>-3</i>
Sociable	Mean	7.25	8.50	<i>1.25</i>	8.40	9.00	<i>0.60</i>
	(SD)	(2.71)	(3.59)	<i>(2.66)</i>	(3.29)	(2.58)	<i>(4.43)</i>
	median	7	8	<i>1.50</i>	8	9	<i>0</i>

7.5.2 The CIRCLE domains

1. **Hostility*** the results show that at base line the treatment group score was significantly more hostile than the control group $p=0.06$ (see Table 7.11). (Mann Whitney) This result shows that the treatment group was at the start of the study less responsive to interaction and possibly more treatment resistant and dangerous than the control group.

When treatment effect was measured between baseline and follow-up, the treatment group made statistically significant improvement across time in the 'hostile' domain ($p=<.04$). This data of on-ward behaviour, recorded observationally by nurses correlates with the PROQ2 findings in the Upper Close and Upper Distant domains. That is to say that the observational rating conducted outside of the treatment groups corresponds with the self-report PROQ2 measure since less hostility would be represented by less sadistically intimidating or tyrannizing and less restrictive, possessive or intrusive behaviours. The control group scores in this domain deteriorated so that both groups had similar scores at post-treatment. Figures A4c.i-vi in Appendix 4c shows the changes across time of both treatment and control groups. Figure A4e2.i in Appendix 4e gives a visual representation of the trends of change across time of the treatment and control groups.

2. **Sociable** The bar charts in Appendix 4e show the trends of change, though there are no statistically significant results in these three domains. In the sociable domain, the control group shows no change with a small improvement which then regresses to the mean. The treatment group shows a trend towards more sociability (Appendix 4e, Fig. A4e2.ii).

3. **Friendly** The control group at baseline is friendlier than the treatment group, but they show a trend towards becoming less friendly over time (Appendix 4e, Fig. A4e2.iii). This is not a statistically significant result and may be attributable to chance. However, it supports the PROQ2 findings, which in the treatment group demonstrate a consistent improvement trend at post-treatment, this was sustained at follow up in the domains of sociability and friendliness.

4. **Withdrawn** The median scores of the withdrawn domain show that at follow up the treatment group are slightly less withdrawn. The control group, on the other hand, regresses to the mean at post treatment indicating no change. Whilst the improvement in the treatment arm is a tiny change, this may be attributable to the treatment effect of interactive group-work because in the PROQ2 NC domain the treatment group improves across time, which indicates greater friendly involvement and interest. Thus, the self-report PROQ2 result and the CIRCLE observational measure results concur in this respect. Furthermore, to withdraw can indicate a healthy need for space without hostility.

Figure A4e2.iv in Appendix 4e gives a visual representation of the trends of change across time of the treatment and control groups.

7.5.3 Treatment effects for domains of CIRCLE by Group

The mean treatment effects in each group as measured in the CIRCLE observational outcome measure were examined for possible correlations with variables of age, length of stay and duration of offending history.

Table 7.13a: Participants below the median age of 34 years

The differences across time within group across the hostile and withdrawn domains are shown as improved by a negative difference (-), (green) which indicates a reduced score.

Improvement in the friendly and sociable domains are shown in green as a positive difference . The differences across time in the control group show a deterioration when indicated in red]

CIRCLE domains		Treatment (n=2; 1 missing)			Control (n=4)		
		Pre-Treatment	Post-Treatment	<i>Difference</i>	Pre-Treatment	Post-Treatment	<i>Difference</i>
Hostile	Mean	6.50	3.00	-3.50	2.25	2.75	0.50
	(SD)	(2.12)	(1.41)	(0.71)	(1.26)	(2.22)	(2.89)
	median	6.50	3	-3.50	2	2	0.50
Withdrawn	Mean	11.50	9.50	-2.00	6.25	6.00	-0.25
	(SD)	(0.71)	(2.12)	(1.41)	(3.30)	(3.16)	(3.30)
	median	11.50	9.50	-2	6.50	6.50	0
Friendly	Mean	9.00	12.50	3.50	13.25	10.50	-2.75
	(SD)	(1.41)	(3.54)	(2.12)	(2.87)	(3.70)	(6.55)
	median	9	12.50	3.50	13	10.50	-2.50
Sociable	Mean	5.00	7.50	2.50	8.50	9.00	0.50
	(SD)	(1.41)	(0.71)	(0.71)	(3.79)	(2.58)	(4.43)
	median	5	7.50	2.50	7	9	0

7.5.4 Treatment effect compared to age

Table 7.13b: Participants at or above the median age of years.

CIRCLE domains		Treatment (n=6)			Control (n=1; 1 missing)		
		Pre-Treatment	Post-Treatment	<i>Difference</i>	Pre-Treatment	Post-Treatment	<i>Difference</i>
Hostile	Mean	6.50	6.33	<i>-0.17</i>	2.00	7.00	<i>5.00</i>
	(SD)	(3.02)	(3.61)	(3.25)			
	median	7	6.50	0			
Withdrawn	Mean	6.50	6.17	<i>-0.33</i>	9.00	11.00	<i>2.00</i>
	(SD)	(4.72)	(4.26)	(2.25)			
	median	5	6.50	<i>-1</i>			
Friendly	Mean	10.33	10.33	0	14.00	4.00	<i>-10</i>
	(SD)	(4.27)	(3.20)	(3.58)			
	median	9	10.50	<i>0.50</i>			
Sociable	Mean	8.00	8.83	<i>0.83</i>	8.00	8.00	0
	(SD)	(2.68)	(4.17)	(2.99)			
	median	8	8.50	<i>0.50</i>			

Mean Treatment effect in domain ‘friendly’ by group T and C to the variable of age.

The younger patients in the treatment group showed most improvement in domain ‘friendly’ over the course of treatment whilst the control group withdrew; this supports the findings from the PROQ2 ND domain (Table 7.13a). The control group needed personal space and privacy but it is not possible to determine whether this was due to positive or negative motivation. However the CIRCLE measure indicates that the control group was not joining in with group activities on the ward. This further questions the validity of this domain of PROQ2 for forensic patients. As the treatment group improved most and the older control group members deteriorated most (Table 7.13b), age may have a relationship to treatability.

Treatment effect in domain ‘friendly’ compared to age:

Overall, patients in the treatment group below the median age of 34 years, improved most in the domain ‘friendly’. All control subjects regardless of age became less friendly.

Mean Treatment effect in domain ‘sociable’ by groups T and C to the variable of age

The younger members of the treatment group improved in sociability whereas members of the control group above the median age became less sociable, and were the only subjects that deteriorated. Thus, age may have a bearing on sociability and therefore on treatability.

Treatment effect in domain ‘withdrawn’ by groups T and C to the variable of age.

Table 26 shows that a reduction in score indicates less withdrawn behaviours, therefore the younger members of the treatment group became less withdrawn but older members of the treatment group became more withdrawn. Overall, younger participants in treatment showed most improvement in the withdrawn domain. This result refers to the treatment participants with psychopathic personality disorder (see T1 and T10 in Table 19). There is no change in the control group.

Treatment participants also improved most in the hostile domain, whereas the older patients above the median age in the control group deteriorated most.

7.5.5 Treatment effects compared with Length of Stay

Table 7.14a: Participants below the median length of stay of 4.75 years.

CIRCLE domains		Treatment (n=2; 1 missing)			Control (n=4)		
		Pre-Treatment	Post-Treatment	<i>Difference</i>	Pre-Treatment	Post-Treatment	<i>Difference</i>
Hostile	Mean	5.50	5.00	<i>-0.50</i>	2.25	4.00	<i>1.75</i>
	(SD)	(0.71)	(4.24)	<i>(3.54)</i>	(1.26)	(2.94)	<i>(3.59)</i>
	median	5.50	5	<i>-0.50</i>	2	4	<i>2.50</i>
Withdrawn	Mean	13.00	11.50	<i>-1.50</i>	6.00	6.75	<i>0.75</i>
	(SD)	(1.41)	(0.71)	<i>(0.71)</i>	(2.94)	(4.03)	<i>(3.20)</i>
	median	13	11.50	<i>-1.50</i>	6.50	7	<i>2</i>
Friendly	Mean	9.50	13.00	<i>3.50</i>	13.50	8.75	<i>-4.75</i>
	(SD)	(0.71)	(2.83)	<i>(2.12)</i>	(2.89)	(4.86)	<i>(7.41)</i>
	median	9.50	13	<i>3.50</i>	13.50	8	<i>-6.50</i>
Sociable	Mean	4.50	6.00	<i>1.50</i>	9.00	9.33	<i>0.33</i>
	(SD)	(0.71)	(1.41)	<i>(2.12)</i>	(3.46)	(3.06)	<i>(5.29)</i>
	median	4.50	6	<i>1.50</i>	8	10	<i>2</i>

Table 7.14b: Participants at or above median length of stay of 4.75 years.

CIRCLE domains		Treatment (n=6)			Control (n=1; 1 missing)		
		Pre-Treatment	Post-Treatment	<i>Difference</i>	Pre-Treatment	Post-Treatment	<i>Difference</i>
Hostile	Mean (SD) median	6.83 (3.06) 8	5.67 (3.61) 6	<i>-1.17</i> (3.37) <i>-2.50</i>	2.00	2.00	<i>0.00</i>
Withdrawn	Mean (SD) median	6.00 (3.85) 5	5.50 (3.39) 6.50	<i>-0.50</i> (2.43) <i>-1</i>	10.00	8.00	<i>-2.00</i>
Friendly	Mean (SD) median	10.17 (4.36) 8.50	10.17 (3.19) 10	<i>0.00</i> (3.58) <i>0.50</i>	13.00	11.00	<i>-2.00</i>
Sociable	Mean (SD) median	8.17 (2.48) 8	9.33 (3.78) 8.50	<i>1.17</i> (2.99) <i>1.50</i>	6.00	8.00	<i>2.00</i>

Domain Friendliness

When investigating the impact of incarceration, those in the treatment group below the median length of stay improved in this domain (Table 7.14a) and there was no change in the control group participants who had stayed over 4.75 years (Table 7.14b). Treatment effect in domain ‘friendly ‘by group and length of stay shows that nursing observations concur with self-report measures in the NC domain with more friendly interest in the treatment group..

Domain Sociable

Those in the treatment group who had been incarcerated for less than the median 4.75 years improved in both sociability and friendliness. All treatment subjects became friendlier, and all control subjects became less friendly. A higher score of deterioration was found for those in the control group below the median Length of Stay (LoS).

Domain Hostile

The control group, regardless of length of stay, became more hostile, while the treatment group reduced in hostility regardless of length of stay. The control group with shorter length of stay was the most hostile. Those in the treatment group with length of stay below the median improved.

Domain Withdrawn

In the treatment group participants below the median length of stay in high secure incarceration became less withdrawn. However, the longer stay patients in treatment showed less improvement which may suggest the impact of institutionalized responses and age. The control group below the median deteriorated, whereas those above the median LoS improved.

7.5.6 Circle Treatment effects compared to Offending History

Table 7.15a: Participants below the median duration of offending history of 14 years.

CIRCLE domains		Treatment (n=2; 1 missing)			Control (n=3)		
		Pre-Treatment	Post-Treatment	<i>Difference</i>	Pre-Treatment	Post-Treatment	<i>Difference</i>
Hostile	Mean	4.00	4.50	<i>0.50</i>	1.67	3.33	<i>1.67</i>
	(SD)	(1.41)	(3.54)	<i>(4.95)</i>	(0.58)	(2.31)	<i>(2.08)</i>
	median	4	4.50	<i>0.50</i>	2	2	<i>1</i>
Withdrawn	Mean	6.50	6.00	<i>-0.50</i>	6.33	7.33	<i>1.00</i>
	(SD)	(7.78)	(7.07)	<i>(0.71)</i>	(4.04)	(2.08)	<i>(2.65)</i>
	median	6.50	6	<i>-0.50</i>	7	8	<i>2</i>
Friendly	Mean	13.00	13.00	<i>0.00</i>	14.33	9.00	<i>-5.33</i>
	(SD)	(4.24)	(2.83)	<i>(7.07)</i>	(2.31)	(2.65)	<i>(4.93)</i>
	median	13	13	<i>0</i>	13	10	<i>-3</i>
Sociable	Mean	7.50	9.50	<i>2.00</i>	9.33	8.00	<i>-1.33</i>
	(SD)	(4.95)	(3.54)	<i>(1.41)</i>	(4.16)	(2.00)	<i>(3.06)</i>
	median	7.50	9.50	<i>2</i>	8	8	<i>-2</i>

Table 7.15b: Participants at or above the median duration of offending history of 14 years.

CIRCLE domains		Treatment (n=6)			Control (n=2; 1 missing)		
		Pre-Treatment	Post-Treatment	<i>Difference</i>	Pre-Treatment	Post-Treatment	<i>Difference</i>
Hostile	Mean	7.33	5.83	<i>-1.50</i>	3.00	4.00	<i>1.00</i>
	(SD)	(2.50)	(3.71)	<i>(2.81)</i>	(1.41)	(4.24)	<i>(5.66)</i>
	median	8	6	<i>-2.50</i>	3	4	<i>1</i>
Withdrawn	Mean	8.17	7.33	<i>-0.83</i>	7.50	6.50	<i>-1.00</i>
	(SD)	(4.12)	(3.44)	<i>(2.48)</i>	(2.12)	(6.36)	<i>(4.24)</i>
	median	8	8	<i>-1.50</i>	7.50	6.50	<i>-1</i>
Friendly	Mean	9.00	10.17	<i>1.17</i>	12.00	9.50	<i>-2.50</i>
	(SD)	(3.29)	(3.19)	<i>(2.64)</i>	(2.83)	(7.78)	<i>(10.61)</i>
	median	8.50	10	<i>1.50</i>	12	9.50	<i>-2.50</i>
Sociable	Mean	7.17	8.17	<i>1.00</i>	7.00	12.00	<i>5.00</i>
	(SD)	(2.32)	(3.87)	<i>(3.03)</i>	(1.41)	(1.41)	<i>(1.41)</i>
	median	7	8	<i>1</i>	7	12	<i>5</i>

The treatment group below the median duration of offending history improved very slightly in the domain of sociability (Table 7.15a). Subjects in treatment above the median in this domain showed almost no change so this may indicate the negative effects of a chronic and ingrained offending history on the capacity to change (minimal improvement) (Table 7.15b).

Domain Friendly

The treatment group became friendlier, and the control group less friendly with no correlation found to the duration of offending history.

Domain Hostile

While the changes are very small but positive in the treatment group, there are trends which would require more investigation in a bigger study to validate the following results.

Domain Withdrawn

In conclusion, there is no correlation between the duration of offending history and the treatment effect in the withdrawn domain.

7.6 H1: IPA Analysis

The IPA analysis of the semi- structured interviews of therapists' observations and experiences drew out six key super-ordinate themes about the G-CAMT method and the Manual:

1. Mutual support through dialogue created bonding.
2. Recognition of mindfully thinking and awareness of others led to reciprocation (give and take) between people
3. Cultural diversity of instruments and group members encouraged group relating and choice.
4. Joyful experience happened through connecting and sharing with others.
5. Mapping techniques by music therapists with the patients in the group sessions helped patients think about individuality and commonalities.
6. Mapping was useful to clarify visually the group's recognition of their relating patterns.

7.6.1 IPA Triangulation PROQ2 octants ND and NC which relate to the primary hypothesis ‘relating to others’

Table 7.16: IPA analysis of emerging themes in the Neutral Distant (ND) domain.

1. As <i>trust developed</i> the group as a whole had <i>more freedom</i> to express themselves musically.
2. Turn taking changed becoming more <i>spacious</i> , which helped listening.
3. The Observe Describe Explore (ODE) technique of G-CAMT facilitated members to be <i>mindful of each other’s space</i> in jointly created music.
4. By exploring new ways of making music, a patient extended his ways of relating.
5. Musical turn taking helped quiet members to have <i>space</i> to participate more equally.

Table 7.16 shows the ND positive qualities of needing personal space and privacy as drawn from the IPA analysis (words in italics denote emerging recurrent themes).

Table 7.17: IPA analysis of emerging themes in the Neutral Close (NC) domain.

1. <i>Resonance between people</i> occurred through listening and creating music together
2. Jointly created ‘playing of music’ freed people up.
3. Cultural aspects of instruments generate <i>interest</i> and dialogue.
4. Mindfully observing, describing and exploring <i>increased communication</i> and allowed for emotional recognition <i>and relating</i> .
5. Hand Drum improvisations encouraged group cohesiveness.
6. <i>Sounding bowl</i> : combination of resonance, visual and tactile senses <i>led to sharing</i> .
7. Sharing, noticing and awareness of others changed the quality of interaction.
8. Mutual support through <i>dialogue created bonding</i> .
9. Recognition of mindfully thinking and <i>awareness of others led to reciprocation</i> (give and take) between people
10. <i>Cultural diversity</i> of instruments and group members <i>encouraged group relating</i> and choice.
11. Joyful experience happened through connecting and sharing with others.
12. <i>Mapping helped</i> patients think about individuality and <i>commonalities</i> .
13. Mapping was useful to clarify visually the group’s recognition of their relating patterns

Table 7.17 shows the NC positive qualities friendly involvement and interest drawn from the IPA analysis.

7.6.2.IPA Triangulation to SPSS Quantitative analysis

Table 7.18: Triangulation of the qualitative IPA analysis of the PROQ2 domains and quantitative SPSS results.

PROQ2 Domains	IPA (Qualitative analysis)		SPSS (Quantitative analysis)
Neutral Close (NC)* Friendly involvement and interest (+)	<u>Musical</u> <ul style="list-style-type: none"> • Resonance • Cultural diversity of the group was represented by instruments • Sound-print was a shared experience • Hand-drum: group-cohesiveness • Sounding-bowl combined resonance, visual, aural and tactile senses, which promoted friendly involvement and interest (sharing) • others could identify with the mood of individuals' unique ways of musical expression = friendly involvement and interest 	<u>Verbal</u> <ul style="list-style-type: none"> • Observe Describe, Explore (ODE) • Interest and dialogue • Toleration of others • Sharing target-problems • Thinking together • sharing, noticing mindfulness of each other developed • dialogue created bonding and support • mindfulness developed reciprocal awareness • connecting and sharing created joy • sharing experiences enabled feelings to change • observing involves listening and connecting 	<ul style="list-style-type: none"> • The treatment group is weighted in having more fear of separation and of being alone at baseline. T1, T10 (7.10) • Treatment group starts with mean score of 23.22, improves steadily. Post-treatment is 22.67 and follow-up is 19.78. Demonstrates consistent improvement over time in friendly involvement and interest. • Excluding outliers: the median at base line is 24, at follow-up 21 showing an improvement of 3points. • The control group at base-line have less fear of separation and being alone with mean score of 20.17, with a very minor improvement at follow up to 19.83. This suggests minimal change for their need for friendly involvement and interest.

	<ul style="list-style-type: none"> Describing and connecting with resonant feeling promoted relating to others. patients said it was easier to be with others in this group 	
	<u>Therapists' experiences</u> <ul style="list-style-type: none"> ODE led to joint activity Rapid group cohesion Mapping enabled mindful group recognition and shared ownership of relating patterns 	
Fear of Separation and of Being Alone	<ul style="list-style-type: none"> Difficult feelings of mourning about saying farewell expressed in jointly-created music rather than words 	
Neutral Distant (ND)* Needing personal space and privacy (+)	<ul style="list-style-type: none"> Group negotiated what to do with all that they had created in the sessions <u>Musical Aspects of space</u> <ul style="list-style-type: none"> More freedom of musical expression developed as trust grew. Listening improved as turn-taking became more spacious Observing and exploring/experimenting (doing) developed mindful respect of each other's space during jointly-created music (described afterwards by members) Exploring in music extended individual ways of relating 	<ul style="list-style-type: none"> This is not a positive attribute for the purposes of the research question Non-verbal aspects of interaction not covered in PROQ2

	<ul style="list-style-type: none"> • Musical turn-taking (sharing) helped quiet members to participate 	
Suspicious, Uncommunicative , Self-reliant (-)		<ul style="list-style-type: none"> • Over time, the treatment group appears to deteriorate in their need for personal space and privacy, therefore if they needed space and privacy they would not be relating to each other but would be on their own. For the purposes of this study and the research question, needing personal space and privacy is a negative quality. The treatment group starts with a base-line mean of 12.66, a post-treatment mean of 16.44 and follow-up 16. • Therefore, I suggest this is a positive effect, which suggests greater sociability. This result is further supported by the CIRCLE measurement, which indicates improved sociability in the treatment group. • The control group starts with a mean of 16, post-treatment 12.17 and follow-up 11.7. This suggests, that this group are preparing to separate and do need more personal space and privacy. Furthermore, that overall that they may be further on in their treatment pathway. This will be explored in greater detail in subsequent correlations.

<p>Lower Neutral (LN) Seeking direction, guidance and advice (+)</p> <p>Helpless, Shunning, Responsibility, Self-denigrating (-)</p>	<p><u>Therapists' experiences</u></p> <ul style="list-style-type: none"> • Manual gives focus, direction, confidence, and clarity; it is different & helped hone skills. • Mapping promoted cognitive processing and developed group interactions (musical and verbal). • Therapist used recorder as melody to guide the group <p><u>Therapists' observations</u></p> <ul style="list-style-type: none"> • Sounding bowl encouraged dialogue and constructive thinking • Large instruments (tam tam) increased feelings of small child-like overwhelmed powerless = vulnerable feelings as therapeutic material • Sound-prints, encouraged and empowered patients to ask the therapist how to play = seeking direction, guidance and advice 	<p>NO SPSS DATA for this domain or for therapists</p>	<p>Words printed in green indicate an interconnection with PROQ2 positive attributes</p>
--	---	---	--

Table 7.18 (above) shows the positive qualities drawn from the IPA analysis, which have been triangulated against the positive PROQ2 domains. Those printed in green refer to novel aspects of the Manual which concur with the triangulated results of positive PROQ2 domains and the IPA analysis of the semi- structured interviews. These include Mindfulness techniques such as ‘Observe, describe, explore technique’, the sound print and sounding bowl, the Target Problem, CAT Mapping, and the Safety Call. (In the statistical analysis of PROQ2 only the negative scores are counted)

Chapter 8 Results: Part 2 Hypothesis 2 and 3

Hypothesis 2 (Emotional Relatedness)

In this chapter, (8.1) provides an overview for the secondary hypothesis in relation to the secondary measures. Firstly the Basic Empathy Scale (BES), in which the statistical results across time and between groups are tabulated in the domains of cognitive empathy, affective empathy and the total score.

8.2 shows the statistical results of the secondary measure MDI in the domain of emotional constriction, these are tabulated across time and between groups. The mean scores of each participant in this domain of the MDI are then tabulated and explored in relation to the clinical cut-off point for psychopathy in order to demonstrate the high levels of treatment resistance in the treatment arm as well as the changes across time in each individual. (8.3, 8.4. and 8.5)

The main qualitative themes relevant to H2 are drawn from the IPA analysis of the semi-structured interviews of music therapists' observations and experiences (stage 5 IPA analysis), and then triangulated against the positive qualities of the three relevant domains of the PROQ2 in relation to H2. These are called Upper Close (UC), Upper Distant (UD) and Lower Distant (UD) The results of the triangulation are then further triangulated with the SPSS statistical results, thereby providing further evidence in support of H2 .Finally the use of instruments in the treatment group is tabulated and discussed with reference to the sound-prints in a relational context.

The following section explores the results of Hypothesis 3 , (8.4) provides a statistical analysis of the Attkisson & Greenfield Patient Satisfaction questionnaire, which was administered to the treatment arm of the study. The attendance statistics are stated and this patient satisfaction data is presented in separate bar charts in the domains of service, help, and satisfaction. Each bar chart is divided into different aspects of these three domains.

(8.5) provides qualitative data from the Patient Satisfaction questionnaire.(AMT-PSQ)

(8.6) names the main qualitative themes relevant to H3 as drawn from the IPA analysis of the semi-structured interviews of music therapists' experiences (stage 5 IPA analysis), which are triangulated against the positive qualities of the relevant domain of the PROQ2 in relation to H3. (UN)

8.1 The secondary hypotheses (H2a)

Men in the treatment group will show an improvement in their emotional relatedness after sixteen sessions of G-CAMT , compared with those in the control group receiving standard care only as measured on the Basic Empathy Scale

8.1.1 Descriptive Statistics: Secondary Outcome Measure Basic Empathy Scale

Table 8.1: Descriptive Statistics of the Basic Empathy Scale domains by Groups and time points (Jolliffe & Farrington, 2006). (Green asterix signifies statistically significant improvement within groups at $p < .05$.)

* sig. difference within groups at $p < .05$

		Time 1: Pre-treatment		Time 3: Post-treatment		Time 4: Follow-up	
		T (n=9)	C (n=6)	T (n=9)	C (n=6)	T (n=9)	C (n=6)
Cognitive empathy	Mean	32.44	33.33	33.89	34.67	34.44	36.50
	(SD)	(3.54)	(4.50)	(7.10)	(3.83)	(4.69)	(2.66)
	median	32*	33.50	35*	34.50	32*	36
Affective empathy	Mean	34.56	37.00	36.44	38.67	36.44	39.33
	(SD)	(6.71)	(4.56)	(6.91)	(6.38)	(6.73)	(6.74)
	median	33	37.50	38	41	40	41
TOTAL score	Mean	67	70.33	70.33	73.33	70.89	75.83
	(SD)	(7.84)	(7.89)	(12.71)	(8.64)	(9.28)	(7.31)
	median	66	69	73	74.50	72	78

The control group is seen from Table 8.1 to be slightly more empathic as their baseline score was higher in total empathy when compared with treatment. Yet their follow-up result did not correlate with any of the PROQ2 scores, which might suggest a false positive. Therefore a further calculation was completed (Table 8.2) to evaluate changes across the duration of the intervention from baseline to post-treatment only, and between groups

The basic empathy scale shows the difference across time and between groups from baseline to post treatment. There was statistical significance in favour of the treatment group, within the group across time in the domain of cognitive empathy. Table 8.2. shows that both groups show a trend of improvement in all three domains across time from baseline to post-treatment with similar mean scores, therefore changes in empathy cannot be attributed of the intervention. This measure alone does not confirm Hypothesis 2.

Table 8.2: Treatment effects pre- and post-treatment by groups.

BES domains		Treatment (n=9)			Control (n=6)		
		Pre-Treatment	Post-Treatment	<i>Difference</i>	Pre-Treatment	Post-Treatment	<i>Difference</i>
Cognitive Empathy	Mean	32.44	33.89	<i>1.44</i>	33.33	34.67	<i>1.33</i>
	(SD)	(3.54)	(7.10)	<i>(5.25)</i>	(4.50)	(3.83)	<i>(3.01)</i>
	median	32	35	<i>1</i>	33.50	34.50	<i>0.50</i>
Affective Empathy	Mean	34.56	36.44	<i>1.89</i>	37.00	38.67	<i>1.67</i>
	(SD)	(6.71)	(6.91)	<i>(6.13)</i>	(4.56)	(6.38)	<i>(6.09)</i>
	median	33	38	<i>3</i>	37.50	41	<i>3.50</i>
TOTAL Score	Mean	67	70.33	<i>3.33</i>	70.33	73.33	<i>3.00</i>
	(SD)	(7.84)	(12.71)	<i>(11.24)</i>	(7.89)	(8.64)	<i>(6.42)</i>
	median	66	73	<i>6</i>	69	74.50	<i>3.50</i>

8.2 H2.Secondary Outcome measure. The Multiscale Dissociation Inventory (MDI) (Briere, J. 2002) domain: emotional constriction

8.2.1 Descriptive Statistics

MDI:

Table 8.3: Descriptive statistics of the MDI domain ‘Emotional Constriction’ by groups and time points.

		Time 1: Pre-treatment		Time 3: Post-treatment		Time 4: Follow-up	
		T (n=9)	C (n=6)	T (n=9)	C (n=6)	T (n=9)	C (n=6)
ECON (Emotional Constriction)	Mean (SD) median	8.33 (4.56) 7	8.33 (4.08) 7.50	8.22 (4.12) 6	8.50 (2.88) 8.50	7.11 (2.76) 6	7.83 (3.43) 7

The Multi-Scale Dissociation Inventory (MDI) showed a small reduction in ‘emotional constriction’ in the treatment group at follow-up with a tiny statistical change of 1 point from a median of 7 to 6 .Mean score 8.33 to 7.11 (Table 8.3). This result may hint at greater freedom of emotional expression. The control group overall from baseline to follow-up had improved by 0.5 on the their median score from 7.5 to 7.0 having got worse at post-treatment.

The treatment group across time became less emotionally constricted with a mean score reduction within group from 8.33 at baseline (SD=4.56) to 7.11 at follow-up (SD=2.76), which may suggest that they have become more able to express their emotions. As meaningful feelings. Emotional Constriction is relevant to the development of empathy in that if there is less constriction on unconscious emotions, which gain meaning, when they become consciously felt as feelings, then more empathy may develop.

The total percentage of the treatment arm above the cut off for clinical concern reduces across time from baseline to follow up from 22% to 11%.

The level of clinical concern in the control arm remains the same at follow up at 17%. Treatment subjects 3 and 6 show greatest improvement.

Looking at individual trends in table 32: the baseline score for T6 is on the clinical cut off point for psychopathy, thus there is a constant trend of improvement sustained at follow-up. T2 is interesting, as he gets worse before he gets better. If this is viewed from an holistic perspective, (like an immunization or homeopathic cure which is effected by a small dose of the substance which creates the illness being administered within the treatment, then this result may be viewed as a positive

response. Two members of the control arm also improved though overall there is no change in the control arm.

Table 8.4: MDI Domain of Emotional Constriction

	<i>ECON 1 (Pre-Treatment)</i>	<i>ECON 3 (Post-Treatment)</i>	<i>ECON 4 (Follow-Up)</i>
<i>T1</i>	7	6	8
<i>T2</i>	5	14	7
<i>T3</i>	10	8	6
<i>T4</i>	5	5	5
<i>T6</i>	13	9	5
<i>T7</i>	5	5	7
<i>T8</i>	7	6	6
<i>T9</i>	5	5	6
<i>T10</i>	18	16	14
<i>Total of clinical concern (n=9)</i>	<i>N=2 (22%)</i>	<i>N=2</i>	<i>N=1 (11%)</i>
<i>C1</i>	7	11	8
<i>C2</i>	5	5	5
<i>C3</i>	8	6	6
<i>C4</i>	5	7	5
<i>C5</i>	9	10	14
<i>C6</i>	16	12	9
<i>Total of clinical concern (n=6)</i>	<i>N=1 (17%)</i>	<i>N=0</i>	<i>N=1 (17%) NO CHANGE</i>

Table 8.4: MDI Domain of Emotional Constriction shows the mean scores by individual participants. The cut off for clinical concern is a score higher than 13, as highlighted in yellow. The higher the score the greater the degree of emotional constriction, reduced scores indicate improvement. The treatment group becomes less emotionally constricted, which suggests they are more able to express themselves.

8.3 IPA Analysis triangulated against PROQ2 octants UC, UD and LD

8.3.1 IPA Analysis triangulated against PROQ2 octant UC domain

The IPA analysis below (Table 8.5) supports the secondary hypothesis in that patients and therapists can recognize feeling safe and helped. UC Positive qualities = protecting, helping and providing for others.

Table 8.5: IPA Triangulation against UC

UC positive qualities drawn from the IPA analysis

(words in italics denote emerging recurrent themes).

- The manual was empowering and *helped* and as a result patients and therapists felt safe.
- By having ‘stop ‘ techniques (as a *protective* function) in jointly-created music, patients remained mindful and did not suffer dissociative phenomena.
- Sound prints (the patient’s unique choice) *helped* people feel safe
- Mindfulness *helped* maintain a safe focus.
- Music varied from loud to reflective in how people *helped* each other.
- When an emotion was recognized and named this *helped* others to reflect on their own feelings.

IPA Analysis of positive attributes:

Sound prints *helped* people feel safe

Mindfulness *helped* maintain a safe focus.

Music varied from loud to reflective in how people *helped* each other.

When an emotion was recognized and named this *helped* others to reflect on their own feelings.]

8.3.2 IPA Analysis triangulated against PROQ2 octants UD Domain

Table 8.6: The semi structured interview triangulated against the PROQ2 Octants in the UD domain

UD positive qualities: controlling and maintaining order, drawn from the IPA analysis (italics denote emerging recurrent themes).

1. Distress as a feeling is visible as musical action, beating a drum as potentially violent, (as supported by Pool and Odell-Miller's research 2011), is sublimated into creating sound.
2. Over-control and out of control could be talked about.
3. Distress as a feeling (about ending therapy) in the treatment groups is visible as musical action, hitting an instrument as potentially violent, was sublimated into creative, loud sounds.
4. Men who have been violent could express soft, gentle and sad feelings; then talk about past cruel behaviour (in the index offence).
5. Over-control and out of control feelings could be talked about.
6. Anger was dispersed
7. Control, freedom and negative behaviours were explored verbally and recognized in jointly-created music.
8. Saying 'no' and 'stop' were new 'exits'.
9. Controlling, maintaining order, involved being open and direct with therapist's focus on group direction, cohesion, safety and sadness in ending and being able to stop.

Table 8.6 describes positive qualities that may validate the findings and interpretation of the high score in the treatment arm, which subsequently improved. The ending of the groups and explanation of the process of mourning for men who have committed murder was described by the music therapists as *difficult*, *sad* and *huge* but the groups connected with this process.

The IPA triangulated analysis of the UD domain validates the positive qualities of controlling and maintaining order, whilst developing ability to express themselves non-verbally. The IPA analysis for the UD domain supports through the therapists' view of the patient, the secondary hypothesis in that both patients and therapists could recognize feeling safe and helped.

8.3.3 IPA Analysis triangulated against PROQ2 octants: LD Domain,

Table 8.7: The semi-structured interview triangulated against the PROQ2 Octants in the LD domain.

<u>LD positive qualities drawn from the IPA analysis</u>	
•	Being able to play loud music together without it being threatening felt ‘important’.
•	The safe and sad ending implied risks of violence were contained (obedient but expressive)
•	In jointly-created music patients could recognize feelings that got too much and had a technique by which to stop acting on impulse.

The IPA triangulated analysis of the LD domain describes emotional relatedness when playing loud music, and suggests ability to express rather than to act out sad feelings. Furthermore, it suggests that the techniques provided for stopping promoted feelings of safety when there was a risk of emotional flooding.

8.4 H2. IPA Stage 5 Triangulation with primary measure PROQ2) UC, UD, LD, LC Domains

Table 8.8: Proq2 domains, qualitative IPA (observations and experiences together), and quantitative SPSS results.

PROQ2 Domains	<u>IPA</u>	<u>SPSS</u>
Upper Close (UC) Positive Qualities (+) Protecting, helping , providing for	<ul style="list-style-type: none"> • Being able to stop the music maintained mindfulness, which felt safe and focused • Observe, describe, explore (ODE) as a joint activity helped everyone to feel safe and able to express negative feelings • Therapist helped patients in jointly created musical endings • Emotion was recognized in music, which varied from loud to reflective through which the group was able to self-reflect on their feelings. • The manual empowered the therapist and gave confidence • Manual gave helpful reassurance as a guide, and helped patients as much as therapist 	<ul style="list-style-type: none"> • Groups did not match at pre-test point: control group showed less psychopathology (score 12.2) than treatment group (score15.4). • Treatment group improved over time (5points) with mean score of 15.4 at pre-test point, 13.3 at post-test and 10.6 at follow-up. • Control group also reported improvement (2.5points) but a slightly smaller one (from 12.2 to 9.7)

Negative Qualities (-) Intrusive, Restrictive, Possessive	<ul style="list-style-type: none"> • The manual was initially tiring and unfamiliar 	
Lower Close (LC) Seeking care and protection (+)	<ul style="list-style-type: none"> • Being together helped relieve distress • Talking about fears of impulsiveness, isolation (seclusion) and control reduced the need to act impulsively • Sound prints and sounding bowl promoted feeling at ease and of safety • Therapist felt effective as a role model to express feeling vulnerable 	<u>NO SPSS DATA for this domain</u>
Fear of Rejection and Disapproval (-)		
Upper Distant (UD)* Controlling and maintaining order (+)	<ul style="list-style-type: none"> • Stop-technique (in the manual by use of an identified instrument) helped to control emotional arousal. • Distress as a feeling is visible as musical action, hitting as potentially violent, is sublimated into creating sound. • Men who have been violent could express soft, gentle and sad feelings; then talk about past cruel behaviour (in the index offence). • Over-control and out of control could be talked about. 	

	<ul style="list-style-type: none"> • Anger was dispersed • Control, freedom and negative behaviours were explored verbally and recognized in jointly-created music • Saying 'no' and 'stop' were new 'exits'. • Ending the sessions and project was a palatable way to think about time limits and other endings. • Setting boundaries and ground rules empowered therapist to feel balanced and in control. • ODE promoted jointly-created activity: music and mapping. • Controlling, maintaining order, involved being open and direct with therapist's focus on group direction, cohesion, safety and sadness in ending and being able to stop. 	
Sadistic, Intimidating, Tyrannizing (-)		<ul style="list-style-type: none"> • The treatment group score shows higher psychopathology at pre-test with score of 20 than the control group with score of 15.8. Groups were not matched in this domain. • Treatment group score suggests this group feels less in control at the end of treatment. However, at follow-up they have settled (suggesting internalized experience) and show slight improvement 19.77 on baseline UD score. This suggests sustainability of treatment effect in this domain. • Control group reports improvement at end. However, they deteriorate at follow-up to original score (Hawthorne effect?)

Lower Distant (LD)* Obedient loyal respectful (+)	<ul style="list-style-type: none"> • Able to play loud music without being threatening suggests mutual respect. • Patients could express themselves being loud and/or feeling sad safely because they had a “stop-technique” (manual). 	<ul style="list-style-type: none"> • Treatment group improved consistently over time. Follow-up score reduced to 18.5.
Acquiescent, Subservient, Withdrawn (-)		<ul style="list-style-type: none"> • Treatment group starts with mean score of 21, therefore generally they are more acquiescent, subservient and withdrawn than the control group who start with mean score of 16. • Control group deteriorates over time to follow-up score of 19, indicating they have become more withdrawn (this supports the CIRCLE outcomes).

8.5 Sound-prints

8.5.1 What is the 'sound-print'?

The sound-print is a unique technique that is novel to G-CAMT. The sound-print is a descriptive name which can be applied by each participant to their preferential sound and choice of instrument; their unique resonance which can be developed over the course of treatment in how each individual becomes recognized by others in the group through their musical 'voice' as their sense of a musical identity develops over the course of the sixteen session treatment. The purpose of the sound print is to help the patient to relate to sounds with which he can recognise that he feels an affinity- in effect a vibrational and relational 'resonance'

8.5.2 IPA Analysis of positive attributes

Sound prints *helped* people feel safe.

The music therapists recorded the sound prints shown below, all the participants use the range of drums

8.5.3 Drums (26% sound- print)

The sensory effect of drumming on a subtle or overt level can be to make an internal non- threatening connection between sound and touch, resulting in aural awareness of self to others in call and response, or to make a threatening communication to signal awareness of self to others or others to self. The tactile effect of using natural drums can help patients to connect through the sensory experience of beating and drumming with their hands, and to start think about what they can do what their hands, whether loud drumming makes their fingers smart and tingle and whether it hurts or not.

8.5.4 The sounding Bowl. (11%)

Three sounding bowls of different sizes were provided for the group sessions. This instrument was unknown to participants, however it ranked as the third in its use as a safe and expressive instrument to use as a sound print. The findings show that the sounding bowl is the most effective instrument in its versatility and combination of sensory effects

Table 8.9: Sound-prints chosen by participants in treatment arm.

Patient Code	Sounding bowl	Bass Instruments (Bass xylophone, Bass bar)	Gong & Cymbal	Drums (Djembe, Slit drum, Conga, Dhol)	Sensory Sounds (Ocean Drum, rainstick, Chimes, Bell Tree)	Tuned Percussion (Marimba, Glockenspiel, Xylophone, Marimbula, Metallophone)	Guitar and Piano	Handheld (Claves, Agogo, egg shakers, tambourine, Tibetan bells)	Recorders
SPSS 1	2 times	4 times	-	4 times	1 time	2 times	-	1 time	-
SPSS 2	-	2 times	3 times	7 times	-	2 times	1 time	-	1 time
SPSS 3	-	1 time	-	6 times	2 times	2 times	2 times	1 time	-
SPSS 4	-	-	-	1 time	-	-	8 times	3 times	-
SPSS 6	3 times	-	5 times	6 times	1 time	-	8 times	-	-
SPSS 7	9 times	1 time	-	5 times	1 time	2 times	-	3 times	-
SPSS 8	2 times	8 times	-	2 times	3 times	8 times	8 times	-	2 times
SPSS 9	-	-	-	1 time	-	-	-	1 time	1 time
SPSS 10	1 time	2 times	5 times	10 times	3 times	2 times	-	2 times	-
<i>Total</i>	17 times (11%)	18 times (11%)	13 times (8%)	42 times (26%)	11 times (7%)	18 times (11%)	27 times (17%)	11 times(7%)	4 times(2%)

Table 8.9 shows the intensity of use of the instruments which patients chose as their sound-prints over the sixteen sessions of G-CAMT.

8.6 Results: Hypothesis 3 Patient Satisfaction and Feasibility of Patient preference Trial

The third hypothesis

A randomised controlled trial is feasible in a high secure hospital treatment setting, when a patient preference methodology is used, as measured by the Attkisson & Greenfield (1994) Client Satisfaction questionnaire CSQ-8UK and the self-report Music Therapy Patient Satisfaction Questionnaire (Beeley and Compton Dickinson, 2010 from (Odell- Miller, Hughes, and Westacott, 2004)) The treatment arm consisted of two treatment groups. Treatment group 1 consisted of 5 patients who were drawn from assessment and treatment wards and a villa ward (The villa wards are for patients who have progressed towards discharge) : 59/80 sessions attended =73.75%. Treatment group 2 consisted of a patient group drawn from long –term treatment wards and a villa ward 66/80 sessions attended = 82.5

8.6.1. Attkisson & Greenfield Patient Satisfaction CSQ-8UK

This self-administered measure was developed for use in mental health programmes (Larsen et.al. 1979) It is a brief 8-item scale. All items are measured on a four point likert scale. The validating paper (Attkisson and Greenfield 1994) states that the internal consistency is very good based on tested values for coefficient alpha which range from .83 to.97, The questions relate directly to the treatment intervention received, therefore the questionnaire was administered at the follow-up session two months after the intervention had been completed to the participants in the treatment arm (N=7). The data collected was inputted to SPSS and mean scores were calculated then bar charts were generated. The questions seek to elicit more detail from patients in five aspects of the service received.

1. The levels of satisfaction with the information provided.
2. The range of treatment.
- 3.The levels of choice within treatment.
4. The amount of help received on the specific problem,
5. Overall satisfaction and whether clients would like to come back for more and whether they would recommend the service.

Within overall satisfaction (Fig.8.1) from a total mean score of 4.00 the quality of the service was rated as ‘excellent’ with a mean score in the treatment group of 3.57.

The lowest mean score of 2.50 was recorded on whether the patients’ needs were met.

8.6.2 Service received. CSQ-8UK

Questions 1 to 4 of the questionnaire asked:

- 1.How would you rate the quality of the service you received?
- 2.Did you get the kind of service you wanted?
- 3.To what extent has our service met you needs?
- 4.If a friend were in need of similar help, would you recommend our service to him or her?

The chart below shows the mean score of the two treatment groups combined, and that that the quality of the service was rated as excellent, the kind of service expected was generally what patients wanted, that the service met most of the patients' needs and that most patients thought they would recommend this service (Fig. 8.1).

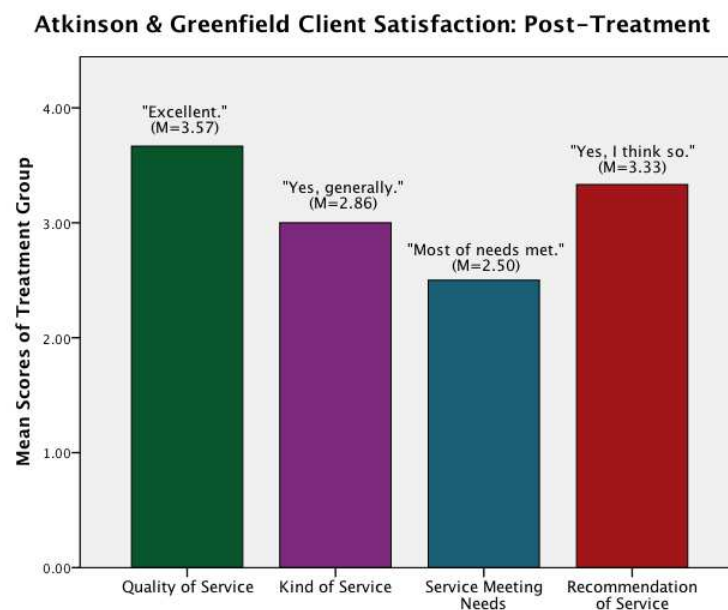


Figure 8.1: Attkisson & Greenfield Client Satisfaction Questionnaire: Q1-Q4 Patient satisfaction in domains of quality, needs met, and recommendation.

8.6.3. Satisfaction on amount of help received. *CSQ-8UK*

Questions 5 to 8 of the questionnaire ask how satisfied the patients were about the amount of help received, whether the help was effective, the overall satisfaction and whether the individual would come back for more and recommend the service (Fig. 8.2).

- 5.How satisfied are you with the amount of help you received?
- 6.Have the services you received helped you to deal more effectively with your problems?
7. In an overall sense how satisfied are you with the service you received?
8. If you were to seek help, would you come back to our service?

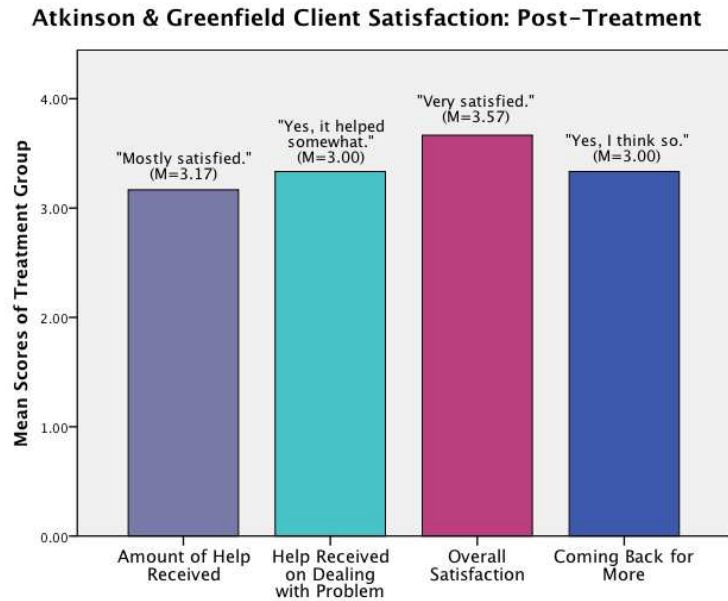


Figure 8.2: Attkisson & Greenfield Client Satisfaction Questionnaire: Q5-Q8 Patient satisfaction in domains of help and acceptability of treatment.

8.6.4 Information, and range of choice in treatment CSQ-8UK

This section of the questionnaire asks four overall questions about satisfaction with the information provided, the range of treatment, whether there was enough choice. The final question was not directly related to patients in high secure treatment with serious mental illness (Fig. 8.3).

Q1: How satisfied are you with the information provided about the services and treatment available to you ?

Q2: Are you satisfied with the range of treatment offered to you?

Q3: Do you feel that you had enough choice about your treatment?

Q4: Which treatment do you prefer for stress, anxiety or depression?

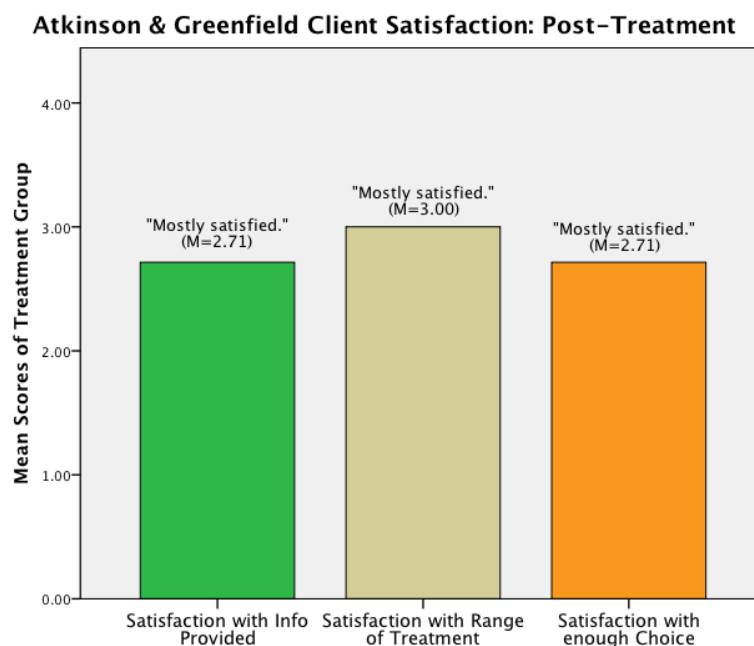


Figure 8.3: Attkisson & Greenfield Client Satisfaction Questionnaire: Q9-Q11 Satisfaction with information, treatment range, and choice.

8.7 Patient Satisfaction Questionnaire (AMT- PSQ)

The Art and Music Therapy Questionnaire (AMT-PSQ) Compton and Beeley from Odell Miller, Hughes and Westacott (2006) was designed specifically to draw out qualitative aspects of non-verbal creative arts interventions. An IPA analysis of the patients own words in written responses (Tables 8.10 and 8.11) concurred with and enlarged on the results of the Attkisson and Greenfield CSQ -8UK. (1994). The recurrent themes which patients rated as helpful aspects were '*sharing, interacting, relaxing, and easy feelings*'. In tables 8.10 and 8.11 the key words are printed in italics.

The two overarching questions are:

1. What was it that made this therapy helpful?
2. How do you think that this therapy has helped you to change?

8.7.1 IPA Analysis of Patient Feedback

Table 8.10: Responses to Question 1. What was it that made this therapy helpful?

IPA Analysis super-ordinate themes:

- An ability to *reflect* developed and was *helpful*
- Able to *learn new skills* with different people
- *Sharing* the expression of emotions when not alone
- *Learnt unusual* and *helpful* ways of being with others
- *Motivated* to come back by energy generated, feeling *relaxed*
- *Communicating* was *helpful*
- Developing *listening* skills had a pay-off: it *helped empathy*
- *Being with others* in the group *helped them learn* to give others space.

Table 8.11: Responses to Question 2. How do you think that this therapy has helped you to change?

- *Self-reflection was possible* on an individual's treatment problem and objective, because he could stop and think.
- *Curiosity* was linked to increased insight
- Patient was able to *relax and have a positive experience* in which he felt accepted.
(Improved self esteem)
- *Feeling an embodied sense of rhythm* facilitated relaxation, which helped with connecting to others
- *Experiencing this intervention helped* this Pt. to understand others and himself and *to have insights*
- Pt. could be *more creatively expressive*
- Pt. *Sharing his 'predicament'* indicated greater acknowledgment of the offence
- Pt could *recognize his feelings*
- Pt could *listen to others better*
- Pt could *understand his own needs and connect* to others
- Safety through non-verbal musical expression encouraged self-reflection

8.8 IPA Analysis triangulated against PROQ2 octants: Upper Neutral (UN domain)

Table 8.12: Semi-structured interviews triangulated against PROQ2 octants: Upper Neutral (UN domain).

UN positive qualities drawn from the IPA analysis (words in italics denote emerging recurrent themes).

- The Manual was a ‘reference guide’, (Therapists) ‘*liked it*’, did not impair autonomy
- Therapists need to *feel competent and skilled* in managing stress to cover the various tasks in final stage.
- *Mapping (specific to the Manual)* helped therapist as much as patients.

Qualitative data of the music therapists’ observations and patient perceptions and experiences were examined for possible correlations with the qualitative changes in relating as demonstrated on the primary outcome measure in the UN domain (Table 8.12). This domain was useful despite no statistical significance in patient outcomes. The positive qualities of leading, guiding and advising are relevant to the music therapists’ skills and to the use of the manual , which was a reference guide. Table 8.6 shows that by feeling competent and skilled the music therapists were able to manage their stress and to lead their groups.

8.9 Therapists’ Satisfaction

Stage 5 of this process involved triangulating the IPA data with the quantitative data of the primary outcome measure PROQ2 (Table 8.13).

Table 8.13: PROQ2 domain Upper Neutral, and IPA analysis of Music Therapists satisfaction

PROQ2 Domains	<u>IPA</u>	<u>SPSS</u>
Upper Neutral (UN) Leading, guiding advising (+)	<ul style="list-style-type: none"> • Manual did not impair autonomy • Cognitive Mapping as a visual aid helped therapists as much as patients. 	<ul style="list-style-type: none"> • At base line both groups are matched in this domain. • In this domain there is slightly more improvement over time in the control group compared to the treatment group. This may indicate greater individual autonomy in the control group and more group-ish behaviour with ability to negotiate in the treatment group, (rather than taking a lead.)
Pompous, Boastful, Dominating, Insulting (-)	None reported	

8.10 Summary.

Birtchnell and Evans (2004) in order to validate the properties of PROQ2, took mean scores on a sample of 276 non-patients and 432 psychotherapy patients of which 125 were men and 307 were women. Over 70% of all the participants were women. They then made comparisons between patients and non- patients. For female participants the non-patients were orientated more towards closeness in their relational patterns, and men scored more in the distant domains. The female patients were more Lower Close (LC) and Lower Distant (LD). Patients scored higher than non-patients on the Upper Close (UC) and Upper Distant (UD) scales. The Upper Distant and Upper Close domains of the PROQ2 outcome measure are of particular interest in the treatment of men who have committed violent offences.

The pilot project to the present study (Lawday and Compton 2013) shows comparable scores to the validating paper and changes over time in the LC, LD and NC domains. These results showed that female patients are more Neutral Close, Lower Close and Lower Distant. than male patients. These domains of greatest change did not replicate in the main study. With the men in the in the present study the UC and UD showed greatest change, thereby highlighting the different ways that men and women respond. The reliability of the findings from the PROQ2 in this study was further validated by calculating the treatment effect across time between baseline and follow-up within and between groups, followed by an exploration for possible correlations with variables of age, length of stay and the duration of offending history (Table 7.6a to Table 7.8b).

The results whilst complex and detailed, show that there is evidence of clinical effectiveness with statistically significant improvements in the UC and UD domains in favour of the treatment group compared to the control, which can be attributed to the independent variable of jointly- created musical improvisation when delivered in the G-CAMT model.

There are positive correlations between the UC and UD domains with the CIRCLE observational measure in how treatment participants became less hostile, despite being a more treatment resistant group. These results are further strengthened by the IPA analysis which was conducted through five stages in which the emerging themes were funnelled and distilled into super-ordinate themes, throughout which an independent research assistant verified and challenged the findings of the principal investigator.

There was significant improvement in favour of the Control group in the ND domain, however the validity of this result is questionable. The ND domain relates to reduction in suspicious, uncommunicative and self-reliant behaviour, thus an increased need for personal space. Therefore

this domain may not accurately measure the effect of a group-work intervention, which is designed to help people relate to each other. This result may be a false-positive as it did not correlate with any of the qualitative findings or with the other outcome measures.

Overall treatment effect against the variable of age: All patients in the LD domain in the treatment group improved despite the treatment group as a whole being older than the control group (Table 7.6a). Those below the median age (Table 7.6b) showed the greatest trend of improvement of -3.33 by becoming less acquiescent, subservient and withdrawn instead developing loyalty, obedience and respect, compared to the control who deteriorated by +3.25. This hints towards the greater brain plasticity and treatability of the younger subjects in general.

In the UC, NC and LD domains (Table 8.13) patients above the median age in the treatment group improved when compared to the control. This difference can be attributed to the intervention which has a positive effect on more treatment resistant, older patients.

Overall treatment effect against duration of offending history and length of stay:

The results in these domain suggests that, despite their levels of treatment resistance and chronic offending history, the treatment group discover how to be more sociable and helpful as a result of G-CAMT. When comparing between groups, those above the median with a chronically long offending history of more than 14 years showed a marked improvement in the UC domain in the treatment group only (Table 7.8b).

The median for the duration of offending history is 14 years as opposed to the length of stay (LoS) in the high secure hospital of 4.75 years.

The latter period (LoS) of incarceration is for the treatment of the index offence, which is frequently preceded by other offences, the overall offending history with repeated patterns of offending behaviour impacts on length of stay contributing to the treatment resistance and risk of recidivism.

There was a marked improvement when comparing treatment and control above the median offending history with a score of -3.17 points in favour of the treatment group in the LD domain. This indicates greater obedience, loyalty and more autonomy through less acquiescent, subservient or withdrawn behaviour. This contrasted with a deterioration of the control group of +4.33 points.

These results were then compared with the base-line to post-treatment results in the observational measure CIRCLE. The trend of change in the withdrawn domain was of improvement by -2.00

for those in the treatment group who were below the median age indicating that they had become more sociable. There was also a minor improvement in the treatment group for those above the median age, whilst there was a deterioration in the control group of +2.00. These results support the primary hypothesis that G-CAMT improves relating to others.

In fact, on the CIRCLE observational measurement (Table 7.11) the control group became more hostile across time compared with the treatment group, despite the fact that at baseline the treatment group were statistically significantly more hostile than the control group ($p < .01$).

A second calculation (Table 7.12) measured the CIRCLE at baseline to post treatment only, because the follow –up data set was incomplete. This measure further verified a difference between the treatment and control groups across time with an improvement by -1.0 in the treatment group compared with a deterioration by +1.40 in the control group.

The IPA analysis involved a detailed exploration of trends of change with qualitative descriptions noted that corresponded to the qualities of the different domains of PROQ2 -both positive and negative. The depth of the subjective exploratory process that is involved for an IPA qualitative analysis contrasts with the impartiality of the quantitative paradigm. This dual process of analysis was necessary in this small sample where p values alone may not be depended on to replicate in a higher powered, large scale study, The mixed methods analysis therefore served a pragmatic purpose, the results of which require further testing towards strengthening the case towards either supporting or rejecting each of the hypotheses.

The results are less conclusive in support of the secondary hypothesis when looking at the BES quantitative data. However, when exploring correlations with results of the third hypothesis; patient satisfaction data and the music therapists' observations and experiences, it becomes apparent that patients in the treatment group developed greater emotional recognition therefore supporting the secondary hypothesis.

Finally, the feasibility of the patient preference model in a randomised controlled trial is supported by the low rate of attrition and high levels of patient participation in completing the satisfaction questionnaires as shown in the results of the CSQ-8UK and the MT-PSQ.

Chapter 9 Discussion and Conclusions

This chapter first gives an overview of the findings, then discusses the findings relevant to Hypothesis 1, comparing the changes in relating to others which were found in this study with those found in other mental health and forensic studies using the PROQ2 primary outcome measure (9.2). The findings relevant to Hypothesis 2 are then discussed, comparing the changes in aspects of emotional relatedness with those found in another forensic study using the BES outcome measure (9.3). The findings on patient satisfaction with G-CAMT are considered in 9.4.1 and 9.4.2. Post-treatment follow-up data, both within the study duration and at 18 months after the end of the study are discussed in section 9.5.

9.6.1 considers concurrent areas of music therapy research within forensic settings and the implications of the present study for future directions in treatment, future research questions, and the use of a treatment manual. 9.6.2 discusses the merits of the patient preference trial; 9.6.3 reviews the mixed methods design employed in the study and the impact of the treatment context in comparison with that of some other forensic treatment contexts. 9.5.4. discusses the study's implications for the supervision and training of music therapists working in forensic psychiatry. 9.7 lists some limitations of the study and makes recommendations for future research in terms of research design, sample selection, information sources, data collection and analysis. A brief statement follows to conclude what this author considers the study has achieved.

9.0 Introduction

The primary, secondary and tertiary hypotheses are supported to an extent by the quantitative statistical outcomes and in the associations that were discovered with the qualitative data analysis, thus supporting the use of the mixed methods approach on this relatively small sample size. The

The closeness and distant axes threw up one problem in the Neutral Distant (ND) domain in measuring a group-work intervention that is designed to promote sharing and relating at a non-verbal musically expressive level. The negative attributes of this domain are suspicion, uncommunicative-ness and self-reliance. Self-reliance may not be a negative when patients have had very little choice over many years of institutionalised living, as they require more self-sufficiency if they are to manage safely in conditions of lesser security. There was no evidence from other measures of suspicious or uncommunicative behaviour from those in the treatment arm.

Given the sample size, the highly statistically significant changes which occurred can cautiously be attributed to the intervention in how men became less self-denigrating and helpless (Lower Neutral LN)(Table 7.4b), as they began to take responsibility and choose, rather than shun responsibility. Furthermore, as they discovered how to make creative choices of musical instruments with the purpose of making jointly created musical improvisation, they became less acquiescent and withdrawn, instead making connections with others (Lower Distant LD). The patients described this process as being 'helpful, creatively expressive and positive'. They were able to self-reflect safely because they could 'stop' and 'think'. This result supported the use of the 'stop' technique and reduced risks of harm or of offence re-enactments. As a result, the men were able to 'share their predicament'. This indicated that the intervention enabled the men to think about their index offence and to come to terms with why they were in hospital. Thus despite their years of incarceration their responses became less acquiescent and withdrawn (LD) and less institutionalised. Instead, they described that they could seek advice, guidance and direction from each other and from the music therapists, and that 'sharing' promoted a group sense of loyalty.

Those above the median of 14 years of incarceration who received the intervention all showed a reduction in pompous, boastful, dominating and insulting behaviour (UN). Group analytic principles were effective within manualised time-limited G-CAMT because collaborative, jointly created musical and verbal dialogue and choice were promoted.

The active ingredients included a choice of musical instruments, some of which became favourite means of emotional expression with which the men developed a connection and relationship. These were selected as their 'sound prints'.

The music therapists described the manual as a useful reference guide and they 'liked' it because it did not impair their autonomy. This is important as it enabled the music therapists to feel 'competent and skilled' in their own right. The mapping techniques were described as helpful to both therapists and patients.

The 'stop' technique promoted a safe environment in which joint activity through mapping (and the 'observe, describe, explore' technique – words attributed to Linehan, 1993), as identified in the manual, helped each individual to develop more self-control, thus discovering expressive ways through which they were managing their own impulsivity with greater autonomy, rather than through external controls. This is important in forensic treatment in terms of risk reduction.

Following the manual also helped to contain dominating behaviours by promoting dialogue. One of the music therapists introduced time limits on improvisations, to help her patients to express and yet contain their anger within a creative group improvisation process. The patients could therefore effectively use the large, potentially dominating instruments (the piano, the guitar and the tam-tam) with others in jointly created improvisation. Dominating behaviour was reduced through the group-work processes of G-CAMT. One patient who had musical skill discovered how to integrate on his instrument rather than being boastful of his skill. These components helped patients and music therapists to feel safe and guided.

The components of G-CAMT were identified in Table 4.1 By understanding these specific ingredients, it could be seen how they contributed to statistically significant improvement in relating to others, in which those receiving the intervention became less intrusive and more able to give and receive help reciprocally (UC). Furthermore, they became more friendly and sociable, with reduction of sadistic, intimidating and tyrannising behaviours at post-treatment (UD). This improvement was sustained and consolidated at follow-up and further supported by the observational measurements (CIRCLE), which demonstrated that less hostile responses were replicated on the ward.

When emotions arose which were recognised and named, this helped others to reflect on their own feelings. This is different to a psychoanalytic interpretation because it is a shared experience that was not exposing or mysterious. Patient choice and collaboration in dialogue, both musical and verbal, helped recovery as measured on the PROQ2.

The qualitative analysis drew out a relationship between the development of trust and a greater sense of creative freedom. The observe, describe, explore (ODE) technique was used specifically towards developing creative musical expression within G-CAMT. It nevertheless also correlated with the development of mindfulness of each other's space (stage one of the manual), during which the exploring stage extended the patient's zone of proximal development (ZPD) in finding new ways to relate (Table 7.16).

Resonance was associated with jointly creating music as a group and experiencing a sense of freedom to express feelings, which enabled psychodynamic resonance between the group members (Table 7.17). The gradual building up of sensory experiences, through seeing, touching, smelling and then hearing, may be considered to equate with scaffolded learning in CAT (Ryle and Kerr, 2002). This occurred most effectively in the use of the sounding bowl, and the dialogical exchange that was possible with the sounding bowl, which led to shared experiences.

The secondary hypothesis was supported by the qualitative analysis, in that joyful experiences happened through the process of relating to others, by way of connecting and sharing, finding commonalities and helping each other, as well as being helped by visual mapping exercises. Distress became visible as a musical action, and once recognised by others, negative feelings about over-control or out of control behaviours could be explored. Men who had been violent could discover 'soft, gentle and sad feelings'. They developed victim empathy and feelings of remorse as they became more able to express anger safely and to assert control over how their anger was dispersed. Participants learnt that they could play loudly without it being frightening or threatening and they learnt how to use 'no' and 'stop' as new relational exits. These techniques had an impact on their control of impulses as they became more able to give each other space and to listen and to wait. Experiencing a prepared ending reduced risks of violence as obedience and expressivity were discovered.

The tertiary hypothesis, with regard to patient choices, was supported, as patients were satisfied with the amount of help and the service that they received and there was a low dropout rate. Their overarching theme was that of 'helpfulness', followed by 'learning and self-reflection, communicating and listening whilst being with others'. There was a correlation between curiosity and insight, and between relaxing and having a positive experience. The sense of embodiment and physical release through drumming helped to create feelings of relaxation.

The primary hypothesis was further supported by patient feedback, in which they felt they could 'connect with others' and they could recognise that 'communicating was helpful'.

9.1 Changes in relating: forensic settings

In the present study within the high secure hospital context the UC scores are statistically significantly lower than for men attending psychotherapy in the community, owing to behaviour modification. As shown through this study in comparison with findings from Birtchnell, et al. (2009), in the treatment arm only, in the UC domain, those who were at or above the median age showed less intrusive, restrictive behaviour. There is a positive correlation between the UN treatment effect and a shorter LoS as patients are less institutionalised. A high score at the assessment stage in the UN domain has implications for treatment in that the most dominating men, who had killed, benefitted from individual work prior to group work (Sleight and Compton Dickinson, 2013). In the NC domain, the indication is that the men in treatment who were above the median age receiving the treatment, reworked ambivalent and insecure attachment patterns, thereby showing less fear of separation and being alone.

When comparing treatment and control with Length of Stay, men above the median Length of Stay all improved in contrast to those below the median, thereby supporting the effectiveness of G-CAMT with long-stay patients in reducing fear of separation and being alone and promoting friendly involvement and interest. In the LC domain, patients in high secure treatment are stable – across time and within groups – in their fear of separation (which is minimal until discharge), owing to the treatment context. Monitoring changes and developments in this domain at an individual level when moving through the treatment pathway can provide an indicator that can help towards assessing the risk of readmission and recidivism. LD learning by listening and understanding others promoted obedient, loyal and respectful responses. In the LN domain the non-judgemental approach and acceptance by others within G-CAMT ameliorated shame and facilitated validation of and by others.

Observational measurements confirmed that G-CAMT had a treatment effect that was replicated on the ward. This result is exciting as it reduced the possibility of the Hawthorne effect. Unlike the control arm, hostility was reduced and friendly and sociable interactions increased.

Birtchnell, et al. (2009) conducted a study that took place over an eight-year period and could therefore consider long-term and subtle changes on the PROQ2. These authors compare PROQ2 assessments of men in two forensic samples: from a medium secure unit (MSU) and from two prison therapeutic communities (PTCs). Men admitted to the MSU may have progressed from high secure treatment or they may have less severe offences than those of men who have killed, thus they had less extreme scores.

The results, whilst conducted with the forensic patient group, are from men who are further developed through their treatment pathways from high secure treatment, thus it may be expected that they have lower PROQ2 scores. These results provide an illuminating comparison of scores which are reflected by the stage of the treatment pathway, thereby showing a reduction in psychopathology as the patient progresses through the stages of recovery following discharge from high to medium secure hospital treatment settings.

The results of the present study can help in ascertaining at which points in MDT treatment patients can benefit most from this intervention, as well as which patients can benefit from it. They throw light on treatment readiness for this intervention. The changes in relating in each of the eight domains of PROQ2 in the present study can be compared with the results of the Birtchnell, et al. (2009) study.

The aim of the Birtchnell, et al. study (ibid) was to see if the male forensic patients and prison

inmates in two separate prison therapeutic community (PTC) institutions show higher mean scores than population-based non-patients; if patients admitted to the MSU were different from patients who were not admitted but who received psychotherapy; and whether over the longer term the PROQ2 scores of prisoners who remained in the PTC treatment setting differed from those who were returned to their prison of origin (non-compliant prisoners are returned prematurely to their prison of origin). The authors were thereby able to ascertain whether the treatment context affected behaviours and the recovery process. By further using data from the earlier Birtchnell and Evans (2004) study, Birtchnell, et al. (ibid) ascertained that the LC and ND scores were most clearly differentiated between male forensic and non-forensic populations. The study reported that forensic men have higher mean scores than the wider male population and that this was more marked in the MSU sample than in the PTC sample.

This phenomenon was attributable to the therapeutic community treatment context of the PTC in which the hierarchy is flattened out and less controlling. Prisoners in a PTC are actively involved in collaboratively organising their own community meetings, which are run on group analytic principles (Scanlon and Adlam, 2012). The use of this model in the PTC in comparison to the MSU indicated that by facilitating patient choice and group participation, male patients could feel empowered in their recovery process. Choice and empowerment are encouraged in the present study through the independent variable of jointly created musical improvisation and a detailed qualitative investigation of the active ingredients of change, thereby filling a gap in the existing knowledge of how change is created.

The qualitative aspects of relating to others as described in each of the PROQ2 domains is discussed with reference to the validating paper (Birtchnell and Evans, 2004) in looking at how behavioural and deeper internal changes occurred in the treatment arm; thereby it is considered whether G-CAMT helps to create lasting changes which may reduce recidivism when patients move to other treatment contexts and beyond.

The high secure patient group had extreme, unrevised relational patterns at the earlier stage of treatment when entering the present study; some of them had never participated in any formal psychotherapeutic or offence-related psychology interventions. Thus their relational patterns were until then unmodified. Furthermore, the patients in the treatment arm of the main study were more treatment resistant and had resided in the high secure treatment setting for longer (Table 7.).

9.1.1 Pompous, boastful, dominating and insulting form of relating (UN)

The Birtchnell, et al. study (ibid) reports that the male population in the MSU treatment arm in the UN domain at baseline has a mean score of 14.3 (SD 8.2). The UN score in the present study

(Table 7.3) shows a higher UN mean score of 19.67 (SD 4.69) at baseline in the treatment group reducing to a mean of 19.00 (SD 5.70) at follow-up, compared with the control group, who are matched in this domain at baseline mean score of 19.83 (SD 4.96). The control group improves to a mean score of 17.00 (SD 4.69) at follow-up. Table 7.1 shows that the control group is more amenable to overall treatment and that the UN result indicates that changes are not attributed to the independent variable.

However, the nature of the index offence impacts on the individual's behaviours and treatability (Sleight and Compton, 2013). This variable impacted on this result because only two of the control group had killed (40%) compared with the treatment group in which six of the nine had killed (66.7%). The negative quality from this domain is dominating behaviour, which was ameliorated to some extent during the intervention, though not to a point of statistical significance. A high score in this domain at the assessment stage has implications for treatment in that the most dominating men with narcissistic personality disorder in combination with the most severe offences would benefit from individual work prior to group work. In this way they can gain some ego strength, and a greater sense of internal security through an established individual therapeutic relationship. This was the case in the piloting stages as described by Lawday and Compton (2013) and Sleight and Compton (2013), as one of the therapists in each of the projects had developed prior individual therapeutic relationships with the participants.

It would be unlikely that patients in a highly controlled, secure, institutionalised setting would have the opportunity to develop skills in the positive attributes of the UN domain by leading, guiding and advising, and the statistical results when comparing treatment and control are not attributable to the intervention. However, these qualities may be inherent in the personalities of some participants and they may come to the fore through other interventions such as being the library or patient council representative on the ward, or by playing the lead guitar or the drum kit part in a band. The intensity of standard care is recorded in Table 7.2, showing a mean of 15 hours (SD 23.28) of recreational music compared with the treatment group mean of 10 hours (SD 16.91) over the implementation period of 27 weeks from assessment to follow-up. Since the control group in their standard care received a great deal more recreational music during the period of the treatment intervention, this may have contributed to their trend of improvement over time.

The positive qualities of the UN domain are shown and discussed in the IPA analysis of the music therapists' observations and experiences in their roles as facilitators of the treatment groups (Table 8.7). There was a correlation between treatment effect in the UN domain and LoS. Those above the median of 14 years of incarceration who received the intervention all showed a

reduction in pompous, boastful, dominating and insulting behaviour (the negative attributions of this domain), whilst there was no change in the control group for those above the median LoS. All participants below the median improved, so this change cannot be attributed to the intervention but it suggests that they are less institutionalised and more responsive to their standard care treatments.

9.1.2 Intrusive, restrictive and possessive form of relating (UC)

Men in high secure treatment are incarcerated because they have been violent towards others and have hurt or killed others. The three upper domains relate to offence-related responses to others. The negative aspects of the upper close domain relate to stalking behaviour as described in the case of the ‘lost boy’ (Compton Dickinson, 2013). It is these types of qualities that the intervention seeks to ameliorate through the technique, as prescribed in the manual, of learning how to observe mindfully, to describe the situation and then to explore (ODE) in relating to others through jointly created improvisation in which space and distance (the concepts that are fundamental to PROQ2) can be experienced in a creative way. Thus, it is of particular value that statistically significant changes in the present study occurred in the UC and UD domains in favour of the treatment group.

Intrusive, restrictive and possessive behaviours are common in men if pathological jealousy occurs, thereby raising feelings of envy – even if these feelings are not ‘felt’ at the time, as they may initially be repressed or dissociated. If these feelings are unrecognised they may lead directly into an instinctive and impulsive behaviour without mindfulness. This lack of self-awareness results in ‘mindless’ behaviour, thereby bypassing both thought and feeling. Reduced scores in this domain in the treatment arm suggest that jointly created musical improvisation can encourage mindful relating to others.

The mean UC score at baseline in the treatment group is lower than that in the validating paper. This may be due to behaviour modification adaptations to the high secure treatment context. The disciplined and controlled nature of the treatment context environment was shown by Compton Dickinson (2006) to have a mediating factor in which patients manifest the desire to be protecting and helpful in order to alleviate feelings of shame. A correlation was found between treatment effect in the UC domain and age. In the treatment arm only, those who were at or above the median age showed fewer intrusive, restrictive behaviours. Older patients in the control group became more intrusive. All participants improved, but the most significant change took place in long-stay patients who had received the treatment.

9.1.3 Fear of separation and of being alone (NC)

The Birtchnell and Shine (2000) study measures scores from three different groups: students, MSU patients and prisoners – reporting an NC mean of 12.8 (SD 7.0) in prisoners. High secure hospital patients in the present study have much higher scores in this domain than MSU patients. The mean score at baseline was 23.22 (SD 4.92) in the treatment arm and 20.17 (SD 6.70) in the control arm. There was improvement in favour of the treatment group across time to follow-up to a mean of 19.78 (SD 7.24). This follow-up score matches that of the control group mean 19.83 (SD 6.16), thereby indicating that the additional intervention G-CAMT had a positive effect in helping the treatment patients who initially had higher scores at baseline to become less fearful of separation by coping with a prepared ending, thereby ameliorating the fear of separation.

The results of the present study in contrast to those of Birtchnell and Shine (ibid) show that the high secure hospital population have particularly disturbed attachment patterns which can be related to numerous historical variables, including the symptoms and signs of schizophrenia. In the phenomenology of schizophrenia, in particular the first-rank symptoms (Schneider, 1959), passivity experiences through delusions of control frequently contribute to the violent acting out of an offence. The perpetrator is both feared and fearful and out of control of himself, as he is controlled by his delusion. In psychosis the patient may have no genuine recall of what he has done until much later in his treatment when insight and clarity of mind develops. Thus this treatment model, which promotes a safely facilitating environment, can offer a haven in which anxieties are alleviated and attachment patterns may be revised and reworked.

In the NC domain, the most striking feature is that men above the median LoS show marked improvement, whereas those in the control arm deteriorate, thereby confirming that G-CAMT is effective with long-stay patients in reducing the fear of separation and in promoting friendly involvement and interest.

9.1.4 Fear of rejection and disapproval (LC)

The properties of the LC domain with fear of rejection and disapproval are associated with emotional relatedness, and therefore to H2. This corresponds to stage two of the G-CAMT manual (Chapter 5).

In their community-based study, Birtchnell, Denman and Okhai (2010) report that the LC domain was most clearly differentiated between community-based patients (baseline mean of 21.2) and non-patients (mean 9.5), with a high effect size at 1.71. This makes sense because this domain explores an individual's need to seek care and protection. The Birtchnell and Evans (2004)

sample had already sought care and protection, and following assessment this sample were on the waiting list for treatment through the NHS referral system, and their results were compared with a general population sample taken from students.

In contrast, patients in high secure hospital treatment are already contained and receiving care and attention, as well as protection from the stresses of the outside world. The high secure environment is quiet, highly organised and structured. This can provide an internal sense of security which can initially be welcomed by patients who on admission are frequently traumatised and confused. They may not actually have known what they were doing wrong at the time of the index offence owing to dissociative and psychotic experiences, and have since gone through the criminal justice system.

Results in the present study and in the single case series modelling stages of G-CAMT (National Institute for Care Excellence, 2007) indicate that the LC phenomenon of low scores with little change over time in high secure treatment was not attributed to the intervention but to the specific context and nature of the high secure hospital environment. The value of the safe environment as helpful in the rehabilitation process is emphasised throughout treatment by both patients and staff; however, progress to the lower levels of security requires consideration of the LC scores to ascertain whether and when an individual patient has the mental capacity to manage without such rigorous physical containment.

Compton Dickinson (2006) provides an example of this in the treatment of 'Colin', who did not sustain the positive changes that he had made in high secure treatment on his first transfer to conditions of lesser security. Casement (2014) explains this phenomenon in listening and learning from the patient, which emanates from the double nature of the transference. By this he is referring to the 'as if' relationship which creates the analytical space that allows the patient to experience enough safety to re-revisit past traumas in the present context. Ryle (1995) refers to the concept of 'as if' being a place where the therapist can gently push where it moves. From this a new 'exit' in CAT terms can be emotionally felt as well as being cognitively understood. This process can create a deeper, felt experience through the sense of embodiment and connection through the central nervous system between brain and physical, emotional sensation. Colin's emergence of unexpressed strong feelings of abandonment in the present and with the emergence of his core wound from the past, provided him with the missing link to individual early experiences in which help was not forthcoming (rather than seeking care and protection, the positive attributes of the LC domain; therefore one can understand his underlying assumption that there was no help).

In adults who have offended, associations of lack of help or safety in childhood frequently have negative roots in childhood hospital or care institution admission where abuse may have taken place. Thus, early trauma and shame may be reactivated unconsciously when feelings of abandonment or neglect have been experienced – yet dissociated from, and not consciously ‘felt’ or recognised – in the confines of a high secure hospital. The past and present experiences cannot therefore be differentiated, following which the patient may struggle to effect a closure on his life in the high secure institution. Pragmatic security measures may impinge on the process, with the patient knowing that he will be transferred in the near future but not knowing the exact day. The final ‘goodbye’ to the relationships built in the high secure hospital with the MDT may therefore become a ruptured and incomplete process. The named nurse may not necessarily be on duty, and issues of loss and feelings of anxiety may arise subsequently through a re-experiencing of the original feelings of abandonment. These can become intolerable, thus a regressed response occurs rather than an adult-state response, and the past and present experiences are not differentiated. This can amount to a post-traumatic stress response. The implication is that careful assessment is needed of how to ameliorate the patient’s need to seek care and attention during treatment.

Throughout the present study, the emphasis has been on how attachment theories underlie the clinical approach. Relating and making attachments, and then experiencing separation through the process of individuation, rather than with undue anxiety, were shown in the development stages to the present study to eventually facilitate ‘Colin’ to move on successfully (Compton Dickinson, 2013). Feeling and grieving his losses, and realising that he could internalize the relationship with the music therapist, then building new working therapeutic alliances ameliorated his fear of ending and of rejection. This work informed the development of the treatment manual.

Positive feelings can be replicated in relationships with nurses and therapists within the walled confines of the high secure hospital, yet the loss of these relationships may result in dissociation from those feelings in the new environment, followed by an inability to grieve the loss of meaningful relationships which had felt nourishing and good. If the internal object relations are inherently bad ones in which the patient constantly snags himself by feeling that he does not deserve good things, or if he remains stuck in a pattern in which good things always go wrong or turn sour, the process of internalising a good enough ‘self to self’ and ‘self to other’ sense of safety after the closure of therapy – when those relationships have ended and are no longer available – may only be possible in severely traumatised patients if compassion and care can be sustained, thereby giving space for the dark and the light, the good and the bad in each individual.

9.1.5 Helpless, shunning responsibility and self-denigrating form of relating (LN)

The changes in favour of the intervention compared with the control are highly significant with regard to the shame and remorse that people who have committed serious offences can feel. The highly statistically significant result in the treatment arm suggests that the non-judgmental approach and acceptance by others within G-CAMT ameliorates shame and facilitates validation of and by others. The key to recovery is whether a patient feels victim empathy. This aspect also has relevance to how the music therapists provide a role in giving direction, advice and guidance: the positive attributes of LN.

9.1.6 Acquiescent, subservient withdrawn form of relating (LD)

Birtchnell and Evans (2004) report a gender difference in the LD scores, with a mean of 12.9 (SD 8.1) for male patients and 17.4 (SD 7.5) for female hospital patients. This contrasts at baseline in the present study with a mean of 20.89 (SD 6.99) in treatment and 16.33 (SD 8.87) in the control arm, thereby indicating the extreme of psychopathology and perhaps of institutionalised responses in high secure hospital patients. The reduced score at follow-up to a mean of 18.56 (SD 7.16) in the treatment arm only indicates that the positive qualities of obedience, loyalty and respect in the LD domain in secure hospitals perpetuates across genders, but may alter in conditions of lower security.

The negative properties of the LD domain are identified as a fear of rejection and disapproval. Birtchnell and Evans (ibid) also point out that pathologically dependent LD patients are inclined to avoid confrontation by being acquiescent, subservient and withdrawn. In their study, the LD scale results clearly differentiated between the patients and the non-patients. And in the present study, their result was further supported with highly significant results in this domain. In looking for correlations with the variable of age, all members of the control arm became more withdrawn, while all treatment patients became less withdrawn. Positive attributes in this domain are of loyalty, which involves a connection to other people or an organisation. The result in the present study suggests greater connection to others, thereby supporting Hypothesis 1.

All control participants, regardless of LoS, became more withdrawn, particularly those who had been incarcerated for more than 14 years. Long-stay patients in treatment improved, whilst no change was observed in those below the median. G-CAMT had a stronger impact on sociability in long-stay patients. All receiving treatment improved, and the greatest effect was for those above the median becoming less withdrawn over time.

9.1.7 Suspicious, uncommunicative and self-reliant form of relating (ND)

The ND domain measures suspicious, uncommunicative and self-reliant behaviour. There is statistical significance of $*P < 0.05$ across time against the treatment effect in the treatment group; however, it is worth considering the positive attributes of this measure: needing personal space and privacy. This may also suggest that the treatment group enjoyed their personal space and privacy at the start of treatment and became less in need of it as the intervention progressed – because they bonded with other group members. There is no supporting evidence from the other measures to suggest that the treatment group became more suspicious, intimidating and tyrannising. This description may be a weakness in this domain of the outcome measure, when applied to the non-verbal active ingredients of music therapy because the latter acts as a catalyst of intra-psychic change in which negative emotions such as suspiciousness and responses such as aggression may be sublimated and transformed through non-verbal creative musical expression (Pool and Odell-Miller, 2011).

The clinical implication is that the treatment group, having effectively survived the time-limited ending as a shared experience, may have developed greater self-reliance as a positive attribute. Furthermore, that the treatment group members may have less need for the positive attributes of personal space and privacy because they discovered how to share and how not to intrude. The latter quality is shown through the reduced scores in the UC domain, which indicate that they are less intrusive and restrictive. Scanlon (2012) demonstrate how group analytic treatment which is conducted in difficult places can open up space for dialogues about difficult subjects which are previously unspoken. The argument could therefore be made that those in the treatment group developed greater ego strength through this group-work approach. Davies, Richards and Barwick (2014) highlight the importance of both the group analytic principles and music therapy as active ingredients for change. The medium of musical improvisation through which non-verbal relating skills develop, or from which words may be able to flow, points towards jointly created music within this time-limited modification of group analytic principles enabling those in a cohesive group to connect more easily to others.

Birtchnell and Evans (2004) report a mean of 18.2 (SD 6.8) at baseline in the ND domain. This is a higher score which can be expected for less contained, community based patients than in the present study, in which the baseline mean score in the treatment group is 12.66 (SD 4.33) and the control mean is 16.00 (SD 7.16), thereby indicating that the control arm were more suspicious and uncommunicative. This is supported by the CIRCLE observational measure in which the control arm became more withdrawn and hostile regardless of age, therefore this result was not attributable to the intervention and suggested they needed more space and privacy. The treatment

group members however have less need for personal space and privacy because they discovered how to share, thus this outcome appears to be a negative change when in fact it may be a positive change. . This finding was supported by examination of the correlation between the reduced scores in the UC domain in the treatment arm, which indicated that the treatment arm were less intrusive and restrictive. Thus, if ego strength had developed in the treatment groups through this group-work intervention and through their non-verbal relating skills using musical improvisation, the suggestion is that they can connect more easily to others.

9.1.8 Sadistic, intimidating and tyrannising form of relating (UD)

The UD domain (as well as the UC domain) relates to offence-related responses to others. It is these two qualities that the intervention seeks to ameliorate through healthier relating to others. Thus it is of particular value that statistically significant changes in the present study occurred in the UD domain in favour of the treatment group.

In the UD domain there was statistically significant difference between groups at post-treatment, with the treatment group apparently worse. However, by follow-up the treatment group median score showed a trend of improvement from baseline. This indicates that the treatment group struggled with the closure process at post-treatment measurement, yet no violent risk incidents were reported on the wards (where treatment subjects were involved throughout the trial), and two ward incidents were reported involving control participants.

Birtchnell and Evans, (2004) report a mean of 12.6 (SD 7.3) at baseline in the UD domain. In the present study, the mean scores at baseline were higher, mean 20 (SD 4.33) as would be expected in patients who have committed violent offences. There was statistical significance $P < 0.05$ at the end of the treatment phase between treatment and control in favour of the control group. This suggests the enormous mental difficulties that this treatment group had in engaging wholeheartedly in bonding with others during group work, and in jointly creating music and then effecting a satisfactory and safe ending. All these factors may have raised enormous fears within them of their own intimidating and tyrannising sadistic behaviour as their musical outlet for emotional expression came to an end. However, despite the negative implication, this is not supported by any reported risks of violence, and by the time of the follow-up the treatment group have assimilated their experiences and show improvement to mean 19.77 (SD 4.97) whilst the control group have deteriorated from their post-treatment measurement mean 15.83 (SD 4.26) to a mean of 17.50 (SD 3.73).

Thus we can conclude that the follow-up proved to be an important consolidation period, during which (the results suggest) the treatment group were able to process, reflect on and internalise

their experience as positive. These follow-up results show that the treatment group had improved within group in this UD domain. This finding is further strengthened in the patient feedback (H3), which was taken at the follow-up session two months after the closure of the weekly sessions (H3).

To summarise the PROQ2 findings:

The follow-up results in the present study in the UC, LN and LD domains demonstrate how patients receiving G-CAMT were able to process their experience of a structured, good enough ending after 16 sessions of the intervention; and the results show sustained progress in favour of the intervention after it was completed, compared with the control group.

Understanding this aspect validates the Birtchnell and Shine (2000) study, which reports high positive correlations between the PROQ2 domains and all the DSM-IV personality scales. Therefore, PROQ2 is appropriate for use in such cases, along with standardised measures for psychopathy.

9.1.9 Secondary measure on relating to others: disengaging (MDI)

In Briere's (2002) validating paper participants' MDI scores varied depending on which group they were in, namely general population, university students, clinical or community. As expected, the general population had the lowest MDI factor scores, and the clinical sample had the highest. The clinical cut-off point, above which indicates psychopathology, in the domain of disengagement is 14.

Table 7.9 shows no change in the treatment arm in the domain of disengagement. In the multi-scale dissociation inventory (MDI. In comparing the treatment and control arms this result may indicate stability in the treatment participants' levels of engagement. Whilst there is no improvement across time, unlike the control arm in the domain of disengagement in the MDI, neither is there any deterioration. This may suggest that dissociative traits may have been safely contained by the intervention within the safety of the therapeutic environment, and that this stability sustained at follow –up. The structure of G-CAMT is to reduce the risk of violence which can erupt if the dissociative psychological defence operates (Compton Dickinson.2006, 2013).

Mitchell (2006) examined symptoms of dissociation in 89 male prisoners. The domain scores in Mitchell's study returned a mean of 13.10, with a significant number of participants (41.6%) reporting experience of disengagement symptoms at or greater than the raw mean of 14.

The mean scores in the present study are curious in that, across time from baseline to follow-up, levels of disengagement increase in both the treatment arm and the control arm (Table 7.10). On further investigation, having controlled for outliers (participants T1 and T10 figure 8.4), by taking the median score there is greater stability in the treatment group, despite a loading against the treatment effect created by the presence of two patients in the treatment arm with a dual diagnosis of mental illness and psychopathic personality disorder. Their individual scores are above the clinical cut-off point, which indicates clinical concern with regard to treatability. The control arm scores are all below the clinical cut-off, which indicates responsiveness to treatment *per se*. In the present study, the median score of the treatment arm remains stable across time at a score of 8, whereas the control arm median increases from the baseline score of 8.50 to the follow-up score of 9. Thus this measure, whilst not statistically significant, adds weight towards confirming Hypothesis 1 that the intervention improves relating to others for men with schizophrenia.

9.1.10 The CIRCLE observational measure: hostile form of relating

The Chart of Interpersonal Reactions in Closed Living Environment (CIRCLE). Blackburn and Glasgow (2006) in the validating paper took a sample of 589 men resident in a secure hospital setting. The Mean score in the hostile domain was 19.74. This is higher than in the present study in which there is significant difference between the treatment and control groups at baseline against the treatment arm.

Those recruited to the control group were, by the nature of their consent to participate, showing their amenability and perhaps also their desire to be seen to be good and to move on, at which point they were not presenting as hostile. However across the time of the present study they become more hostile. Since they had choice in whether or not to have the intervention, an argument may be made that this is a valid result rather than attributing this deterioration to patient disgruntlement at not receiving the treatment.

9.1.11 Withdrawn form of relating

In the withdrawn domain the control group in comparison are more withdrawn at post-treatment, this supports the primary hypothesis that as an interactive group-work intervention G-CAMT increased relating to others.

9.1.12 Sociable and sociable ways of relating

Those on or above the median age showed the strongest trend of improvement thereby further confirming the primary hypothesis that G-CAMT improved relating to others, furthermore that older patients can show the greatest amount of change despite treatment resistance.

9.1.13 Relation aspects in the use of instruments

Of the sensory instruments, ocean drum, rain stick and bell tree are used as sound effects but are not used as much as the sounding bowls for verbal exploration and jointly-created musical improvisation within the group process. The sounding bowl proved effective in stimulating curiosity, dialogue and exploration. The guitar and piano were rated together at 17%, second in intensity of use as the patients' selected sound -prints. These two instruments can both have a dominant effect on the group and its work which may give patients confidence in their ability to be heard and to lead an improvisation, however the piano and guitar were not introduced until stage two of the treatment because they have the potential to be overwhelming.

The sounding bowl provided the greatest range in terms of expressivity and ease in which it can be played and selected as a sound-print.

1. From the visual sense- the aesthetic qualities of the sounding bowl stimulated creative imagination about what the individual could see in the qualities of the grain and textures of the wood, pegs and strings.
2. The tactile sense provided a dimension within which to work with metaphor and reflection on the 'rough and the smooth' textures,
3. The olfactory sense stimulated thoughts about how a living tree that had fallen could be transformed honed and seasoned by a craftsman, thus inspiring the inner potential of the individual.
4. The aural sense provided a greater range and potential for participants to 'observe, describe and explore' prior to engaging in a dialogue with another. The dialogue could therefore begin as an inner dialogue about and with the other 'object'.
5. Interpersonal relating then developed into a shared dialogue with the sounding bowl creating the connection between two people who could alternate plucking the strings, thereby creating their own music.
5. Development of group awareness as the sounding bowl was used effectively in group improvisation.

6. Through use of the sounding bowl participants through discovered in a non-threatening way various unknown aspects of themselves, using the metaphor of the instrument being previously unknown to them, like the unknown parts of themselves.

The results of the main study demonstrated that strong feelings could be accessed and expressed, through the use of powerful musical instruments such as the Tam Tam, the Piano and the Drums, and that new feelings of gentleness and sharing were experienced through the use of the sounding bowl and with the additional CAT structures which facilitated a satisfactory closure. Patients reached a point of acceptance of within the pre-agreed time- limited boundaries.

9.2 Emotional relatedness and the second hypothesis

Jung (1960) described feelings as the conscious products of the emotions. The latter emanate from unconscious complexes that are made up of core patterns of emotions. Unlike the impulsivity and intensity of emotions that are geared towards survival, feelings are considered more low-key, stable and sustained over time, as a result of which the present author suggests that in order to recognize them, feelings require quiet mindfulness and the ability to self-reflect. Feelings can tell us how to live whereas emotions tell us instinctively what we like or dislike.

Through the development of emotional relatedness patients such as when ‘Craig’ in Sleight and Compton (2013) gradually discovered that he could be ‘sad’ when appropriate. This recognition of feelings also occurred for ‘Colin’, the ‘Lost Boy’ in Compton Dickinson (2013, p162.) He described feeling ‘sadness on his chest’ for the first time in response to a powerfully bonding experience towards the music therapist who played the sounding bowl in response to his mood. His anger arose after having located his own rage and sadness towards his mother, which had been reflected in a negative transference. This example also highlights the need for patients to be able to express negativity and anger to their music therapist with safety and authenticity for both of them.

9.2.1 Empathy

Central to the exploration of clinical effectiveness of G-CAMT model is the concept that dialogically created musical improvisation is the creative bridge, which can promote mindful thought and feelings. Tinnin (1990) hypothesised that music created this bridging effect in communications across the corpus callosum between the left and right hemispheres of the brain. Blood and Zatorre (2001) used positron emission topography (PET) scans to study neural mechanisms underlying intensely pleasurable responses to music. Their findings showed that as the music ‘chill’ factor intensified, the cerebral blood flow increased to areas of the brain which are associated with emotional reward and arousal, these areas are also active in response to food,

sex and drugs of abuse. Thus the same brain circuitry is activated, namely the amygdala, orbital cortex and ventral medial pre-frontal cortex.

Fachner (2009) further explains that the experience of shivers and chills down the spine were the phenomenon, which enabled Blood, and Zatorre (ibid) to discover that musical information reaches brain structures that convey emotion. He explains how chemically induced altered states of consciousness together with music can be studied as psycho-physiological models of altered states of consciousness, in which through rituals in music, archetypal symbols can be accessed. The balance of pharmacology and the non-medical intervention of music therapy may stimulate the patient as well as helping with motivation and emotional regulation. In shamanic rituals of the Celtic tradition, (Bates 2004) drumming alone is used to change the brain waves, by which an altered state is reached in which insights from deep within the unconscious may be discovered.

Jolliffe and Farrington in their meta-analysis (2006) found that offender non-offender comparison studies which did control for intelligence showed significantly lower mean effect sizes than those that did not control for intelligence. This is supported by the results in the present study in which the mean effect sizes are slightly higher than those in the validating paper. The small numbers in this study suggested that there were no significant effects which can be reliably attributed to the independent variable. However there are trends, which are seen by comparing the median scores.

Jolliffe and Farrington (ibid) report gender differences in empathy scores for both the cognitive and affective scales of the BES. Females scored significantly higher than males. In their study of male participants, the relationship between the basic empathy scale and personality suggested a significant positive correlation between the cognitive measure of the basic empathy scale and the personality quality of extraversion. This relationship was also significant when extraversion was compared to the total basic empathy scale for males but not for females. As expected all scales of the basic empathy scale show significant correlations with agreeableness to both males and females but interestingly there were positive correlations between all of the scales in the basic empathy.

This results in the present study on this measure support those in the validating paper. However, whilst the positive change in the treatment arm is not statistically significant, the expressive and specific qualities inherent in the manualised and structured G-CAMT model, when compared with the components of standard care, which included non-clinical musical interventions, suggest that this is a valid result attributable to the independent variable (manualised music therapy) rather than to just making or listening to music as part of standard care

9.2.2 Cognitive empathy

In the cognitive empathy domain, the treatment group demonstrated statistically significant improvement in cognitive empathy across time at post-treatment. However, this was not sustained at follow-up. This suggests either that they forgot, which in itself is a dissociative trait, or that a longer period of treatment would be required to develop cognitive empathy at deeper, internalised levels, and that therefore further consideration needs to be given to the cognitive aspects of this intervention

9.2.3 Affective empathy

The salient change is in affective empathy in the treatment group, which may be attributed to the independent variable – jointly created musical improvisation. The scores improve across time in the treatment group and these are sustained at follow-up despite being lower at baseline than those of the control group. This suggests an internalisation of the ability to recognise and express emotional empathy towards others. The control group appear to have more affective empathy at pre-treatment, this is probably due to their average younger age, lots of standard care and shorter length of stay, however this higher level of empathy is not confirmed by the CIRCLE observational measurement and the BES score may be the Hawthorne effect and thus a false positive.

9.2.4 Emotional constriction (MDI)

Comparison of the Secondary Measure The Multi-Scale Dissociation Inventory (MDI) between the validating paper (Briere et al., 2005) and the results of this study for the emotional constriction domain. The cut off for clinical concern in this domain is 13 (Table 7.10). In Mitchell's (2006) study the participants' overall mean score was 11.82, with 44% of participants at or above the clinical cut-off score of 13 for this domain. Results in the present study, after controlling for outliers, show a median score at baseline in the treatment arm of 7, reduced to a score of 6 at post treatment and remaining stable at follow-up. This suggests sustainability of treatment effect compared with the control group who fluctuate from a base-line median of 7.50, deteriorating at post-treatment to 8.50 and marginally improving at follow-up with a median score of 7.

9.3 Satisfaction with G-CAMT

9.3.1 Patient satisfaction. Attkisson & Greenfield 1994).

Patients in the present study describe the intervention as ‘rewarding and helpful’ The sustainable effect, which to a great extent may be attributed to the closure techniques used specifically in G-CAMT, along with the tools that are named in the IPA Analysis, ameliorated the often unspeakable fears in the patients’ association between endings and death.

Furthermore, the data analysis comparing treatment effect against variables of age, years of incarceration and offending history showed that the treatment group members on average were older, more treatment resistant owing to longer offending history and longer periods of incarceration (7.1). Despite this weighting disadvantage as compared with the treatment group, their improvement across time to follow-up was steady but slower and less pronounced than that of the younger more treatment responsive control group.

The high levels of attendance in the treatment group and the willingness of control group subjects to complete all the questionnaires indicates that a partially randomised patient preference trial is feasible in the high secure hospital setting.

9.3.2 Therapist satisfaction

The IPA analysis drew out UN qualities of leading, guiding and advising, and the music therapists reported that the manual did not impair their autonomy, but rather that it served as a guide, and furthermore that the cognitive mapping and learning how to formulate SDRs provided a visual aid and helped both themselves and the patients.

9.4 Implications for future treatment: forensic music therapy

There are important developments in forensic music therapy research in Europe and America. These will be considered in order to set the present study in context. The goal of music therapists working internationally in forensic settings was discussed at the World Congress of Music Therapy (Tucek and Fachner 2014 p13.) (The question of how music therapy may contribute to a reduction in recidivism was agreed as a priority. If a collaboration of international researchers in future were to prove that music therapy could contribute positively to the reduction of recidivism, the intervention would gain greater credibility, increasing the availability of clinical services in the field of music therapy.

A systematic review of music therapy practice and outcomes with acute adult psychiatric in-patients by Carr, Odell-Miller and Priebe (2013) identified 98 papers of which 35 had research

results. The aims in acute care concerned communication, engagement and inter-personal relationships, but sample sizes were small. This review identifies that there was no single model developed for adults in acute psychiatric care, and recommended that further research is needed to identify specific music therapy models. The themes drawn from this review support the present study and the development of G-CAMT. The recommendations may indicate further exploration of context -specific models as in the present study, by which specific treatment needs of specific populations can be targeted. The generalisability of a structured forensic music therapy model such as G-CAMT also requires further testing.

A group analytic music therapy group with less structure may bring emotional qualities to the fore over a longer period of time. This is not possible within the time-limited structure of the current NHS multi-disciplinary forensic treatment pathways. Indeed, it raised anxiety levels on a relatively new DSPS unit described by Hervey and Odell-Miller (2013). Their qualitative research project of staff perceptions showed from the staff responses that psychodynamic music therapy was viewed as powerful but potentially harmful. There was ambivalence about music therapy on a psychodynamic model when it accessed the patient's emotions, which, if it re-activated past trauma, was viewed as unhelpful. This was a context specific finding in the treatment of men who have been violent. In a well-established psychodynamic culture the response may have been more receptive. Data analysis showed that there was apprehension about these patients discovering enjoyment and freedom.

Thus in developing the G-CAMT model the question of how feelings can be managed and tailored towards the overall treatment goal of recovery presented a major challenge. Patients may gain cognitive understanding of empathy, which may be experienced emotionally firstly if an empathic music therapist or staff member can connect to a patient with compassion, (rather than that staff member reflecting the patient's self-loathing, shame and disgust.) The development of empathy is a challenge to both patient and therapist, but once the patient feels empathy this can be a new experience to which he may choose to reciprocate with empathy.

Bensimon et.al (2013) considered the relaxing effect of pre-recorded music on prisoners' levels of anxiety and anger. With a sample of N=48 state anxiety decreased in the treatment group, as did state anger. This intervention may provide symptomatic relief, which promotes quality of life whilst in prison, but which may not address the underlying offence-related behaviours that brought these people to prison in the first place. This approach would probably not be accepted as part of psychological treatment within the mainstream of a multi-disciplinary NHS forensic treatment programme, but it is useful in that less anxious patients can self-reflect more easily, and safety and risk are considered in the treatment approach. This could be useful if specific aims and

objectives are applied which relate to the index offence and reduction of recidivism. The question remains unanswered about whether listening to music can have a positive and lasting effect which may ameliorate offence related behaviours and perverse thinking patterns.

O'Grady et.al (2014) conducted a small qualitative case study with seven participants on the effect on women performing music in a prison in Australia. A valuable finding in this grounded theory analysis was information on when, rather than if, performing music can help women therapeutically whilst in high security prisons. The clinical implication may be that a positive effect in narcissistic recognition can occur through performance, and this hypothesis is further supported by the work of Macquire and Merrick (2013) who applied a recovery approach towards helping two patients who played in a band as part of a music therapy group. However, the latter, whilst an exciting development, would be viewed as very expensive in terms of the staff to patient ratio, and it may not be viable over the long-term in the current NHS.

The RCT conducted by Xi Jing Chen et al. (2013) In Chinese prisons provided the experimental group with two sessions of ninety-minute duration of music therapy a week for ten weeks (20 sessions). That is to say, twice a week, high doses of music therapy with a view to reduce symptoms of anxiety and depression. Dose intensity of this magnitude, even over a short duration, would not be feasible within the financial constraints of the United Kingdom NHS. There were no follow-up measurements in this trial to ascertain sustainability of treatment. The high levels of attention received during the intervention (IV) were not compared with a comparable intervention but merely to 'treatment as usual' which was a basic prison regime rather than a structured MDT programme, thus it is questionable whether changes can be reliably attributed to the independent variable (IV) of music therapy, rather than to receiving and doing something which was pleasant. In this quantitative RCT, the principal investigator had a research assistant to help with the recruitment of a good number of participants, and the RA delivered both the outcome measures and the intervention herself, which might compromise her position as an objectively neutral quantitative researcher as is usually required in an RCT, thus it may be argued that this creates an observer bias. There is no qualitative evidence from the patients themselves about what they felt were helpful aspects of the intervention. This is nevertheless a huge achievement to deliver a large-scale project, and collaboration between nations and national centers for music therapy could lead towards the development of greater rigour in a multi-centred study that utilised the G-CAMT manual to control for variables and to guide music therapists who may have only generic supervision on site.

Crimmens (2012) examined the links between aggression and avoidant learning in a maximum-security penitential setting in the USA. Taking a neuro-scientific approach she researched hypo-

reactivity and frontal lobe changes to aggressive responses. She explored the pro-social qualities of music and her study questioned what happened to the reporting of aggression on the wards, in relation to the recording of ameliorating interventions to aggression such as music therapy, the latter being not well reported. Crimmens explored the different musical interventions and questioned why there were fewer sessions in maximum-security facilities in the USA than in other facilities. This she discovered was due to higher rates of burn out in staff and greater security risks causing sessions to be cancelled. One can therefore conclude that the delivery of music therapy in high secure treatment settings is restricted and at times constrained by the greater number of security procedures through which risks of violence are controlled.

Crimmens has considered what types of music intervention might or might not be helpful to this population. She hypothesises that to bring down levels of stimulation through pre-recorded relaxation or music assisted meditation may not be helpful in reducing aggression in the long term, compared to music combo improvisation groups which are rewarding rather than punishing in their pro-social nature. This is exciting research, which acknowledges the value of active music making, playing in a combo in emotional release and self-expression. An international collaboration could possibly lead towards a three-armed RCT, which compared combo playing with G-CAMT, and with passive listening groups.

This author suggests that further research may explore how to achieve a balance between the levels of repose and inner peace, which may be achieved in reflective meditation, compared to the levels of jointly created activity and catharsis possible in jointly-created music making. These aspects are explored in developments to the research treatment manual in the present study, one objective of which was to promote further understanding of the diversity of musical techniques require to mediate emotional responses.

9.4.1 The pragmatics and purpose of a manual

Bitsika and Sharpley (2006) state that there have been some challenges to the reliance upon data from randomised controlled clinical trials when identifying evidence-based psychotherapy treatments and that the use of treatment manuals does not result in uniform and beneficial outcomes. Similarly, data shows that some evidence-based treatments are little better than non-specific counselling and that the search for those therapies or components that are effective has been largely unsuccessful.

In an attempt to extend the debate about evidence-based treatments, and drawing upon those aspects of cognitive and behavioural therapies that have been shown to be effective in most settings, these authors describe outcomes analysis and therapy as the means of assisting clients to

understand their own behaviour as (sometimes unwanted) adaptations to environmental demands, following which the aim is to learn alternative ways of achieving the goals that they want to pursue. This does not take into account the social, cultural and familial background and learnt patterns, which are central to a CAT reformulation and sequential diagrammatic reformulation (SDR). The music therapists in the present study learnt how to work with SDRs and mapping in their CAMT weekly supervision sessions and they replicated this process with their patient groups.

Gold, et al. (2014) conducted a single-site RCT with short-stay prisoners in Norway. The independent variable, music therapy, was not standardised or manualised; anxiety, depression and social functioning were measured. It was not possible to measure any between-group comparisons, which is puzzling. Furthermore the short stay sentences and low baseline levels of psychological disturbance of the inmates impeded analysis of results, Presumably they had relatively normal functioning following petty offences, which presents a whole different set of challenges to consider for the implementation of a research project in this setting. The recommendations of this study include careful consideration of future suitable research settings and better comparison conditions.

Undoubtedly whilst a high secure hospital is a challenging environment in which to propose and implement a study, it is also a closed environment and there is not the same problem of drop out with patient suddenly leaving or not being able to attend as in the community study (Talwar, Maratos et. al. 2006).

This is helpful to know, as the present study, despite many obstacles to overcome within the high secure setting, would appear to be a more feasible context for ongoing forensic music therapy research. A collaboration with these international colleagues who are highly regarded quantitative music therapy researchers would be welcomed in the UK through the international association of forensic psychotherapists, since if a multi-centred trial was undertaken across medium and low secure sites, the problems of attrition and evaluation that Gold et.al (ibid) experienced could be addressed by learning from their experience.

Health-care professionals cannot help but have feelings about their patients, although in the traditional model of 'caring' this was considered to be risky and inappropriate, leading to other defences such as denial and de-personalisation of patients. Boundary violations may occur between staff and patients when feelings have arisen and the psychodynamics of power have overwhelmed the integrity and professional standards of carers. Devereux (2012) explores the impact of this on the lives of patients. Coe and Gabbard (2012) explore whether professionals

who have transgressed boundaries are beyond help. The manual helped the music therapists with guidance on how to hold appropriate therapeutic boundaries when faced with challenges as feelings arose.

Gender-specific differences are important in exploring the results because the pilot project was conducted with women, and the main study was conducted with men. Adshead (2003) maintains that the relational needs of women are more diverse than simply those related to gender, and cites Coid et al. (2000) who state that if they are admitted to medium secure services, the number who have committed homicide is higher than men, yet they are deemed less of a risk than men to the general public because referral is usually triggered by self-harm and other disturbed behaviours. Leith (2014) states that there is a dearth of music therapists working in prisons with female prisoners who only make up 5% of the prison population. Her research compared different treatment lengths and dose effect as well as whether music therapy helped the women to engage in re-settlement programmes. Future research building on Leith's (ibid) findings may well be developed since the high secure hospital site of the present study is now advising prison services and collaborating on arts therapies service development.

The reason for the gender specific difference between the pilot and the main study was initially pragmatic in terms of the hospital ward that was responsive and prepared to welcome a research pilot project was an enhanced medium secure unit for women. The directorate that had the greatest responsiveness and need for the main study was that for severe mentally ill men in high secure treatment. The positive aspect of the gender difference between the pilot and the main study is that G-CAMT was found to be acceptable to both male and female patients and the results showed how traumatised men and women respond differently. This was shown in the different domains of significant change, however this difference had not been anticipated in advance of the data analysis of the main study.

Birtchnell and Evans (ibid) verified that men scored more in the distant domains. The data analysis revealed and confirmed that men are more prone to externalise and act out conflict whereas women are more likely to become submissive and depressed. Lawday and Compton (2013) report that the women were reticent about expressing their feelings and required a great deal of sensitive, gentle support and encouragement to engage in jointly created musical improvisation in which their improvisations were short and aesthetically mediated to express moods rather than primarily cathartic in quality. This contrasts with the main study treatment groups in the present study, where one of the music therapists decided to employ a negotiated agreed time limit for improvising as a containing technique.

Hakvoort (2014) explored multi-faceted ways of using music therapy in forensic settings within a CBT approach for which she developed a manual for anger management; She demonstrates how musical improvisation can contain offence enactments rather than fearing these responses since the creative expression compensated for the patient's maladaptive relating and became a learning curve for both patient and therapist. Storz (2014) has further explored the process of development of trust with a paranoid and psychotic patient. She emphasizes that the musical relationship enables one to try out different patterns of relationship so that they can be experienced and become clearer.

The diversity of these approaches, which have arisen synchronistically without prior sharing, appear to have a commonality with the present study: that is to say, that the active ingredient of change is the musical improvisation within the therapeutic relationships that are formed.

The present study is novel partly because it is focused around the production of a clinical treatment manual. The current trend, since the planning of the present study, is that many models of therapy describe mindfulness techniques. However, in G-CAMT this is not done in a prescriptive manner, as music therapists may have their own mindfulness techniques, which are equally effective. The purpose of mindfulness in G-CAMT is novel in that it is tailored specifically to the development of jointly –created musical improvisation, and to engagement on an intimate level with one's own sound-print. Through gradually building on musical and inter=personal harmony towards an ability to tolerate greater dissonance and the ability to create and endure satisfactory endings. Endings are challenging for treatment resistant men and women who have been violent because they are associated with death.

Emotional recognition is a common thread through music therapy literature, however the way in which emotional understanding is built up gradually is novel to G-CAMT as a music therapy model. This can be explained in the manner in which it is achieved in CAT as a scaffolded process of development through which the zone of proximal development is extended. The musical, non-verbal nature of the process is unique to G-CAMT, thus the strength of the underlying theoretical model lends weight to the efficacy of the intervention.

Interpersonal effectiveness was seen to develop rapidly within the G-CAMT process, and unlike the DBT skills based programme (Linehan 1993), this development preceded the distress tolerance stage. Thus, in the enhancements to the manual, Stage 3 and Stage 4 were reversed from that in the original research treatment manual which followed the DBT stages that governed the over-arching MDT Treatment programme. The development of inter-personal effectiveness at an earlier stage than that of a DBT programme can be attributed to the non –didactic group

analytic principles in combination with robust structures to contain a safe and satisfactory closure whilst facilitating the emotional effect of both achievement and mourning.

Finally this section cannot end without acknowledging the research of Hannibal (2014) who used the mentalisation model in music therapy treatment of borderline personality disorder and Strethow (2014) who has completed a major study on music therapy and borderline personality disorder. These are major contributions to the field, but regrettably since they are not directly related to the diagnostic category of the present study, the word limit precludes a full description though wider exploration of the music therapy field with specific diagnostic needs requires consideration, as does the development of shared commonalities and expertise in international forensic music therapy.

9.4.2 Patient preference trial

The CSQ-8UK asks a difficult generic question about whether the service meets the patient's needs. No single intervention in an MDT approach is designed to meet all the patient's needs. Some patients responded that they 'did not know what their needs were', thus this response has influenced this result. (Figure 8.1) Satisfaction within various domains with the amount of help received ranged from mostly satisfied with the amount of help received (mean 3.17) to very satisfied with the overall service, (mean 3.57) Finally, satisfaction with information, range and choice of the service received was rated by all participants as 'mostly satisfied' (mean 2.7, 3.0 and 2.7 respectively).

9.4.3 Mixed methods design

In quantitative research the researcher tries to eliminate bias completely whereas qualitative research is all about understanding that bias will happen. A purely quantitative hospital -wide RCT was beyond the scope of a doctoral research project in this setting, and it was not feasible in the high secure setting because of the configuration of services and directorates with separate management teams and other planned research projects. The principal investigator, following the piloting stages, revised the methodology. The smaller numbers recruited meant that the study is not well powered and that p values alone will not reflect the true effect. The Principal Investigator was masked to the allocation status of all participants, until she began the clinical supervision of the music therapists. At this point it became impossible for the music therapists to describe patient presentation without referring to those in treatment by name, as their index offences and overall needs and behaviours required consideration.

Jolliffe and Farrington (2006) emphasise that it is important not to rely on statistical significance

as this can indicate a large effect in a small sample or a small effect in a large sample, therefore a significant result does not necessarily indicate a strong effect, and alternatively a non-significant result does not necessarily indicate a weak effect. It is therefore suggested differences across time should be measured, as secondary to differences between the treatment and control groups, and a more meaningful way of interpreting the effect size can be provided by converting the results to the differences between the two groups. This is what was done in the analysis of this study.

9.4.4 Supervision and training

Wigram (2002) discusses the stages of training for music therapists, as they move from an initial observational setting, to a ten-week placement followed by a six-month placement. The introduction of student placements at the research site was important in giving music therapists access to what it is like to work within a locked environment. Staff and students have to undertake a two-week induction course prior to any clinical work, so ideally the six-month placement can be the most valuable to both the host institution and to the student. Students visited the research site for a day of observing the arts therapies team and this alone, with fruitful dialogue, helped many towards work contracts in this and other forensic settings.

The manual was described as a helpful guide by the experienced music therapists who delivered the research project, and it will be a new departure for music therapy students to follow a manual. Music Therapists are encouraged to think for themselves and the manual is there to keep them and everyone else safe and as a benchmark from which to begin and to further develop music therapy techniques along with jointly-created improvisation -within whatever medium is most familiar to the music therapist, rather than as a restrictive measure. Mapping techniques are new for music therapists to learn, however more music therapists are training in CAT, and CAT supervisors are increasingly supervising music therapists. Training involves learning about the parallel processes of clinical work, and the institution as a whole. The mindfulness techniques increased communication and have an impact on healthy team relating per-se. The learning curve for music therapy students in the forensic environment is frequently about how to engage with their own feelings when their patients are often dissociated, at which times there can be a terrible feeling of emptiness. The feelings between self and other have to be recognised, located and overcome if one is to learn how to use the counter-transference. Mindfully observing, describing and exploring increased the communication and allowed for emotional recognition and relating. The musical turn-taking helped quiet members to have space to participate more equally and the jointly created 'playing of music' freed people up.

Odell-Miller (2013) considers the complex layers and relationships which operate for the clinical supervision of music therapists working in forensic settings: to the organisation and employing agency, the secure unit, the relationship between the supervisee and her own music as well as her music therapy skills, her attitude to herself, to her patients, to her supervisor, to the MDTs and to her training and skills. She further points out the value of working with supervisees away from the clinical treatment area because there are potentially toxic dynamics within the confines of the secure area and the high levels of anxiety make it more difficult to think objectively and clearly. Clarity, objectivity and a safe thinking space are the basis on which the therapist and patient are contained and feel safe. Odell -Miller) gives several examples which demonstrate the process by which a healthy, reciprocal supervisor- to- supervisee relationship can enable the music therapist to see aspects of her patient to which she may have been blind within the treatment context, thereby reducing the risk of over-involvement or disconnection.

The implications for supervision in the present study are that effective clinical supervision took place in a group format, and that this does not require a CAT or a music therapy accredited supervisor if the model is understood and the manual is followed, nor does it require weekly face to face contact as technology has developed to a point in which remote video -conferencing can be facilitated. The quality of the treatment and the well-being of supervisees may gain most benefit by cost -effective weekly input in this way.

However, the presence of untreated post-traumatic stressors in forensic patients and their reactivation of similar responses in the present requires greater consideration as a risk factor and in how to understand and treat men and women who have committed offences. The CAT model can provide this level of understanding through the process of reformulation. Music therapists can apply verbally and in sequential mapping these reformulation techniques when they are supervised in the CAT model and when reflecting on the historical and relational aspects of each patient's life course, through which a forensic formulation of the underlying factors which precipitated the offence can be achieved. Further light is thrown on this process through an objective understanding in supervision of how jointly created musical improvisation can reflect the mental state of an individual.

9.6 Limitations and future research

9.6.1 Recruitment procedure and data collection

Even though the sample of this study had been randomised, the sample may still be a potential source of bias because it is small and there was attrition from the control group more than the treatment group. Randomisation can only eliminate bias between groups and then only if the

sample size is large enough. If patients are recruited from a select group then there will be a bias no matter how large the sample – but crucially not *between* the groups. The sample in the present study is however representative of the population, particularly as relatively new admissions who are recognised as being less mentally stable are included. At this early stage of secure hospital treatment, patients are less able to engage in therapeutic interventions due to the traumatic effects of both the index offence and in having recently gone through the criminal justice system. There were two newly admitted patients in the treatment arm, one of whom dropped out after one session thereby contributing to attrition but indicating that G-CAMT is more appropriate for long-stay patients.

An accurate power calculation was conducted (and initially the required number of patients were recruited), the quantitative results were subsequently compromised due to the loss of four patients because of mental health deterioration and managerial failure to employ a translator for one patient who signed up to participate. The risk of spurious results due to the loss of power was counteracted by conducting a detailed qualitative analysis. The results of this IPA analysis serve a central purpose in the present study, the aim of which is to produce and publish an evidence based treatment manual as the central outcome.

Therefore the triangulation process was undertaken by which the analysis of the semi-structured interviews, which were conducted with the music therapists to ascertain their observations and experiences of the processes and the patients, were compared with the qualitative and statistical results of a highly sophisticated and sensitive primary outcome measure- namely the PROQ2. By then dividing the sample to those above and below the median in relevant variables the risk of multiple testing may be questioned. However, this argument is refuted as the process was not an issue of repeat testing of the same aspect, but rather of the exploration of detailed differences and trends of change across the small sample and between groups. In this way a sceptical view of the p values of statistical significance could be taken and the results further explored within the individual differences of participants across this two-armed trial in which after attrition the two arms were not matched.

Leese (2006) reports that ethnic minority groups are over-represented in the high-secure hospital population. The population in this study reflects these findings, but there was an inclusion failure following recruitment of an Asian patient who had chosen to participate, because management failed to employ an Urdu translator. Thus this willing participant was unable to take part in the study. He was offered the treatment after the study finished. Obstacles such as these may be attributable to the pragmatics and financial aspects, however it is disappointing as it may also indicate a lack of priority or motivation in which unconsciously racist views may persist. Thus,

omission bias in recruitment occurred and as a result, sample ethnicity corresponded to the general population rather than to the high-secure hospital.

Attrition has an impact on therapeutic alliance. Consideration was given towards utilising the Bennett *et al.* (2006) CAT methodology and tools in resolving threats to the therapeutic alliance. They cite Martin *et al.* (2000) who state that the most consistent predictor of outcome in psychotherapy is the quality of the therapeutic relationship. Whilst the therapeutic relationships of all group members with the music therapist is a central factor, within a group setting the techniques for resolving threats will be different to those employed in individual therapy. This could be measured with the working alliance inventory (Horvath *et. al.*, 1989). However, it was clear that to monitor the music therapists, who were already qualified and experienced and under stress in adhering to a manual in a research project, this further evaluation may have been felt as a threat to their competency when in fact the attendance figures are testament to their ability to contain and support therapeutic engagement.

9.6.2 Data collection:

A further limitation of this study may be attributed to data collection. The mid-point data of PROQ2 was incomplete and taken prior to mid-point due to music therapists' planned annual leave. Thus, it was decided to eliminate this time-point from the analysis after preliminary investigation.

The CIRCLE observational data that was recorded on the wards provided evidence for sustainable changes in relating outside of the treatment groups. The purpose was to see if treatment effect sustained beyond the therapeutic context. It was however difficult to ensure reliable data collection as this relied on the named nurses to complete and return the questionnaires. Blackburn and Glasgow's (2006) criteria for completion of the CIRCLE state that the nurse must have known the patient for at least one month. Therefore much relied on nursing shift patterns. The named nurses were encouraged to objectively assess their patients, though as they were not officially masked to the status of the patients, they may have wished to do so in a favourable light, thereby creating bias. Full datasets were analysed at baseline and post-treatment, albeit sporadically returned to the arts therapies department. The follow-up data was incomplete. However, the advantage was that this data was entirely independent from that provided by those involved in the treatment intervention and the self-report data collection process.

A further limitation should be mentioned as regards transcription of the semi-structured interviews. Encrypted transcription from the recommended digital Dictaphone was not included

in the identified stream of research funding; therefore the Dictaphone was not purchased. This meant that the vocal expressions of the music therapists with hesitations and thoughtful ruminations were not captured. Poor equipment was borrowed from another department, and this manual Dictaphone was not made available at the second transcription point after stage one of the manual, thus losing that data point. Two of the secretaries in the therapies and education department transcribed from these very poor recordings and were sometimes unable to make out some of the words or the feeling behind them.

As regards choice of measures, it is questionable whether all of the PROQ2 domains could accurately measure treatment effect of group music therapy as compared to standard care as the control. For instance, this is questionable for the ND domain of needing personal space and privacy, since the independent variable is non-verbal jointly created musical improvisation. Thus, the statistical result in this domain of the Treatment arm deteriorating and the Control arm improving may be a type 1 error; that is a false positive effect in the treatment group of suspicious, uncommunicative and self-reliant behaviour as a negative attribute. This was not observed or detected on other measures or in the IPA analysis.

The use of the BES as a measure for social desirability may be questionable. Jolliffe and Farrington (2006) state that few studies have investigated the possibility that intelligence may influence cognitive and or effective empathy, because intelligence relates to verbal fluency, whereas music therapy is primarily a non-verbal creative means of expression which can be effective without words and which need not involve intelligence, although it does involve sensitivity to others and intuition. The IQs of patients at this hospital are not formally measured; therefore changes in empathy could not be correlated against this variable, which is a further limitation. The basic empathy scale is not significantly related to social desirability because a valid measure of empathy should measure a participant's empathy rather than how empathic the person wishes to be perceived by others, so it is questionable whether this relates in any way to how participants relate to each other.

Interviewer bias and response bias may also need to be taken into consideration. The research assistant briefed the participants not to disclose which treatment arm they were in, but this may have become apparent during the interviews.

Subjects who have committed violent offences and who frequently feel shameful want to give socially acceptable answers for fear of being judged for their past acts of violence. This is addressed on page 1 of the PROQ 2 questionnaire, which invites participants to try to answer as they really are rather than how they would like to be. This aspect was further covered by several

‘dummy’ training sessions, which the principal investigator provided for the staff nurse who was recruited as the research assistant to lead on the delivery of the outcome measures. Over several training sessions she and her assistants came to understand how to deliver the questionnaires so that patients could think about themselves honestly, however her assistant was not always available to verify the consistency of the procedure, and on occasion this role was taken by whoever was available on the ward.

9.6.3 Time-limited treatment modifications

Patient progress through multi-disciplinary treatment programmes from high to medium secure treatment is a prolonged process over years, with constant risk assessments until the patient has proved to himself and to his MDT that he is sufficiently well to be transferred to conditions of lower security, therefore it is relevant to measure relating to others in recognition of this as a gradual psychodynamic process of intra-psychic self to self change over time. This was shown on the PROQ2 outcome measure over the longer term by Birtchnell and Shuker (2008) who administered the PROQ2 at pre-admission, 3 then 9 months after admission and one year later which was not possible in the present study.

Dose effect The standard length for an NHS community based CAT treatment is sixteen sessions, for more serious cases twenty-four sessions. The present study’s sixteen sessions of ninety minutes once weekly was an inadequate duration of treatment for patients who are incarcerated, violent, dangerous and treatment resistant. The indication for an optimum dose for patients who have offended and who are in secure hospital settings may be 32 sessions. This was not possible because of the lack of the human resources required to maintain research conditions in the high secure setting.

9.6.4 Musical analysis

Bruscia (1987) developed Improvisation Assessment Profiles (IAPs) through which audio-recorded musical analysis is graded through retrospective listening analysis. This was beyond the scope of the present study. The integration profile of the IAPs categorises musical input as undifferentiated; fused; integrated; differentiated or over- differentiated. This is a laborious process, which nevertheless considers different components of musical improvisation. These include evaluation of rhythmic, melodic and textural structure and also descriptive analysis of the timbres of the music. However the subjective variables of the external assessor’s assessment cannot be eliminated. Bruscia also explores congruence in terms of verbal reaction to musical improvisation and interpersonal congruence. Results are charted onto graphs looking at the

longitudinal progression through treatment in relation to the number of musical episodes and their frequency.

Mathematical accuracy of measurement can be achieved in the musical domains of frequency, duration and pitch of improvisations. Notably this form of meta-analysis has developed in Finland (Erkkila, 2013), and in the UK through the Institute of Musical Research. The latter exists to facilitate research in music of all traditions and eras, and to support freelance and affiliated scholars alike. Music technology and computer software have advanced so that changes through music therapy interventions can be seen to provide evidence for changes in brain activity. Erkkila, Punkanen and Fachner (2011), conducted a randomised controlled trial that explored frontal lobe activity with depressed clients receiving individual music therapy and standard care compared with standard care only.

The present study looked at the patients' choice of instruments, and music therapists observed how they played and experienced the impact of their playing. However, musical improvisations could not be recorded, therefore retrospective analysis of how individuals jointly created their own music could not be explored. The music therapists however kept detailed anonymised clinical notes, which could be used in a future study.

9.7. Future directions

9.7.1. Suggestions for future research in forensic and early intervention

The findings in the UN domain, whilst not statistically significant, displayed trends of change, which have implications for G-CAMT when considering the positive effects, as well as the risks and rewards of playing in a band or combo. One implication for future treatment is that G-CAMT is a suitable intervention to develop improved relating to others, prior to playing in a band in a functional and democratic way without the risks which manifest with the negative impact of the UN qualities of pompous, boastful, insulting or dominating behaviour, which can be counter-therapeutic. This aspect is supported when comparing G-CAMT treatment effect with the variable of offending history (Tables 7.8a, 7.8b). Those above the median of 14 years offending history in the treatment arm became slightly less hostile thus they responded to the intervention. The control group above the median years of offending history became more hostile, thus, based on the negative responses in the control arm there was no ameliorating trend indicated from the many hours of playing in a band or recreational listening which was included in their standard care (Table 7.2).

The statistical results in the only two domains of the MDI secondary measure that were examined, namely disengagement and emotional constriction, are inconclusive. However on closer qualitative inspection these results suggest that there are positive implications for the levels of containment and the effect of mindfulness techniques that are provided by G-CAMT. This was shown in the apparent deterioration in the control arm in these domains, who had a higher intensity of recreational and passive music listening / making, (appendix 6) but showed no reduction in dissociation, which suggest greater disengagement and a lack of mindfulness. This aspect requires far more investigation in a separate study.

The CIRCLE observational measures showed that all treatment subjects improved in their relating to others as they became less hostile, all control subjects were more hostile, and a correlation was found in the duration of offending history with this Treatment effect: treatment participants with long offending history improved more than those below the median; control subjects with short offending history deteriorated less than those with a long history, further supporting the UN finding that the control participants above the median duration of offending history had no ameliorating input to their levels of hostility. This result correlates positively with the PROQ 2 results of the treatment effect on longer stay patients. This UN result suggests that within the boundaries of a G-CAMT treatment, the hostile, boastful and dominating behaviours are ameliorated because they are unacceptable to the culture of the group, to other members and in respect of the music therapist's role. However the impact of this group work model requires testing on a much larger sample across multiple sites in a three armed trial in which one arm are randomised to combo playing, one arm to G-CAMT and one arm to passive music listening.

Table 9.1 shows the follow-up data which were collected two years after the end of the trial to ascertain whether G-CAMT had a positive impact on recovery time and length of stay in a high secure hospital. Table 9.2 shows that seven of the nine treatment participants moved to lower levels of secure hospital treatment within a mean time of nineteen months, compared with the control group, of which only four moved on within a mean time of twenty-seven months and two remained in high secure hospital. This is a promising result, which suggests that G-CAMT contributes to a more rapid movement through the treatment pathway and has implications for future research. This research should focus on the economics and cost effectiveness of providing G-CAMT by comparing its cost with the average length of stay, with the cost of the average length of MDT individual treatment in high secure hospital settings

Table 9.1: Overall sample

Groups combined (n = 15)	
<i>Moved on</i>	<i>No movement</i>
N=11 (73.3%) Median = 26 months Mean = 21 months SD = 9.84 Range = 6-32 months	N=4 (26.7%)

Table 9.2: Comparison of treatment and control groups

Treatment Group (n=9)		Control Group (n=6)	
<i>Moved on</i>	<i>No movement</i>	<i>Moved on</i>	<i>No movement</i>
N=7 (78%) Median = 16 months Mean = 19 months SD = 11.52 Range = 6-32 months	N=2 (22%)	N=4 (66%) Median = 26.5 months Mean = 25.5 months SD = 4.65 Range = 19-30 months	N=2 (33%)

9.7.2. The treatment pathway

The present study fills a gap in the evidence- base because G-CAMT was clinically tested with participants who were at different stages of their treatment pathway. It was implemented with men who have serious and enduring mental illness whilst they all continued to attend their standard multi-disciplinary treatment programme without disruption. Whilst this was challenging to the recruitment and implementation process, the present study was integrated and accepted across the different stages of the MDT treatment pathways that the individual participants had reached.

The recommendations for inclusion of G-CAMT within the overall treatment pathway for women in enhanced medium secure treatment, which followed from the second pilot, were made on the grounds that G-CAMT added flexibility to an MDT over-arching DBT model. G-CAMT fitted into the overall DBT treatment programme at stage one -mindfulness; stage two, which includes soothing and expressive activities and stage three of overall treatment, which includes exploration and change. (Compton Dickinson, Adlam and Odell-Miller pps 214-215) This is extraordinary as until this time the DBT and CAT models were not accepted as compatible with each other and the music therapists had no DBT training, they simply followed the stages of the G-CAMT manual. The pilot project findings concluded that since the DBT model applies constraints to exploratory work G-CAMT had a place that all stakeholders considered was more suitable for patients who struggled with didactic skills-based treatment approaches.

9.7.3. The role of music therapy with death and spirituality

Aldridge and Fachner (2009) demonstrate how music therapy can elicit altered states of consciousness through which suffering can be transcended; how across cultures and within different traditions, healing can occur through music therapy for those with addictions, those with traumatic memories and for those who are dying. Aldridge (ibid) cites Hartley (1999) who emphasised that music therapy in palliative care facilitates a spiritual connection because end of life work is just as much about affirming life and seeing dying as a normal process.

Spiritual support and guidance in each of the religions is provided as part of the MDT approach in high secure forensic services, where over many years some have lived out their lives naturally at the hospital. The current approaches and developments as described in this thesis, are about a changing attitude, which continues to evolve towards recovery and away from incarceration and with a spiritually enlightened and physically embodied approach to the use of music as therapy.

Death is not so normal a prospect to men who have killed or maimed others. It is an ever present and highly emotive issue or it is often too hard to think about. In the case of those whose minds have been perverted or damaged, they can express and recognise the reality of darkness in their souls, as is demonstrated in the naming and mapping out of self-states in the present study. It takes a certain sort of strong yet gentle music therapist to be able to contain and support her patients to share the fact that they individually may have dark states which as a group they could all identify with: the 'hell- collapsed place' and the 'pit of despair'. Thus the treatment manual can provide support towards the ability for the music therapist to see the whole person.

Offences often occur through a lack of ability to deal with unconscious emotions, and the first form of envy that many human beings experience is that of sibling envy, a process that is

generally recognised as one of the most vicious instinctive processes culminating in survival or death. This fundamental fact provides some justification for the application of the relational theories described in this thesis to the treatment approach. Recognition of how those powerful feelings can surface in the present and may be enacted through something as simple as someone else in a group having chosen one's own 'sound-print' can be a healing process of amelioration and comfort. There can be deep symbolism in this process, because by working to the treatment manual that is designed to help music therapists to manage and contain risks of violence, no one gets hurt and harmony can follow from dissonance in both the music and in resolving group conflicts through how people relate to each other.

Forensic patients frequently grapple with remorse and some of them express the desire for absolution. Whilst music therapy cannot provide the latter, it can provide a soothing and safe place that helps them to mourn and come to terms with their underlying core wound and life course. A part of a person may seem to die after a profound loss or mis-deed. In CAT terminology the re-activation of the core wound can mean that they may never be the same again. However, the human spirit of compassion, shown in how others relate to them, and how society views the possibility of repair and redemption for men and women in high secure treatment, may be the deciding factor between the development, or decline of the human race.

These patients have lived through serious mental illness and breakdown; they have grappled with feelings of remorse or loss of hope. This thesis describes these psychological wounds, which frequently arise through trauma, and which are located deep within specific areas of the brain.

The current science of how the brain works continues to evolve; this science can be applied to clinical practice and future research as treatment approaches develop. G-CAMT was designed to improve the individual's control over impulsive responses thereby reducing the risks of violence. In this way to develop recognition of the instinctive responses as well as an ability to use higher mental processes in finding new ways to relate, (in CAT terms 'exits') This may only occur where there is a full acceptance that humans can commit the most evil and cruel of acts, if they become consumed by psychosis, darkness or wickedness. The G-CAMT intervention was shown to facilitate intra-psychic and external changes in self to self and self to others relational abilities, thereby (to use a CAT term) extending each individual's zone of proximal development (ZPD).

For patients who live with disability or who have an incurable or an unseen but manageable psychiatric illness, a full recovery to normality is probably not possible. However, greater levels of functioning and quality of life can be achieved. Multiple factors including deprivation lead to feelings of destructive envy that in turn can lead to cruelty, loss of control and impulsivity and

cold-blooded calculated murder. Whether this was at a time of a dissociated 'self-state' or whether there is a loss of psychological mindfulness, patients themselves describe the enactment of their offence in a variety of ways, and frequently come to realize that they were terrifying to others and also terrified.

Music Therapists working in forensic settings are witnesses to those with serious and enduring mental illness who describe their own suffering prior to a psychotic and destructive act. The patient's distressed lack of intentionality or insight is a contrast to the narrative of a pre-meditated murder. So, to finish with an experience of a man who had committed more than one murder: this man came to recognize through his music therapy treatment the roots of his dissociated rage that manifested outwardly as uncontrollable blushing. The CAT reformulation of this visible symptom went far deeper in explaining to him his previously incomprehensible feelings of abandonment which originated in his pre-verbal experiences as an unwanted, unplanned baby, who at only a few days old was dumped on a doorstep and abandoned either to be found or die. The process of recovery in adult life began only when this patient understood why he had committed his violent acts over the same number of days as those between his abandonment in infancy and in being adopted. This may be viewed either as a curious coincidence of the unconscious, or of meaningful chance and synchronicity with the violent re-enactment of primary rage. At the point of poignant recognition of his abandoned infant self-state, and his abandonment of any feeling toward his victims he wept for the first time in many years. Tears of remorse and regret flowed which were not only at the recognition of his own vulnerability as an infant who almost died; how he had lost forever his birth mother, despite one can assume his screaming blue murder and going bright red in the process; but also his sorrow in how he had abandoned himself to self-hatred, as a victim of childhood abuses, as well as hatred of others as the perpetrator who had acted out his primary rage so violently.

Suffering as part of the human condition may be viewed in many ways and processed either positively as a learning opportunity or with negative submission. The traumatic responses to momentous life-events which can injure the brain, may lead to delayed grief response in which mourning is impaired and depression develops. One may argue that the positive approach that is taken in CBT is to challenge catastrophic thinking patterns. However the catastrophic events themselves, as the above vignette demonstrates in the abandonment of a newborn baby, firstly require empathic understanding and acknowledgement. In CAT the source of the trauma is traced back to earlier relational sources, in childhood experiences and unconscious emotions, thereby making for an holistic model of treatment.

Since our knowledge of the brain has increased through with the development of fMRI scanning, there is a changing attitude in mental health towards the hope of recovery through the understanding that the plasticity of the brain in some conditions can sustain and adapt to injury; thereby leading to the instillation of hope when a loss of function occurs after psychological and/or physical trauma. This brings me full circle to reflect on my first proposal for a PhD study ten years ago, which could not be implemented as access to fMRI scanning was not available. Whilst the present study may be seen as conventional in comparison to the technology of fMRI, I now know that it is the patients themselves through their active involvement, who can provide deep levels of scientific understanding for clinicians and researchers about what works.

9.8 Summary of Conclusions

For general use in psychiatric settings, where much depends on the structure of the MDT approach, the present study provides a model that has been clinically tested across genders in rigorous conditions in medium and high secure levels of treatment with meticulous quantitative analysis and highly detailed and refined qualitative analysis of data. The significant results showed improvement in sociability and friendliness in favour of the treatment arm, thereby supporting the primary hypothesis. The model proved to be acceptable to patients and music therapists, and as a result it is already gaining recognition by healthcare organisations. The constraints, which are imposed within MDT time-limited approaches, do not allow for the depth of exploration and pace of a purely psychoanalytic approach. However, G-CAMT was effective in addressing the target problems and aims that were pre-agreed between the music therapists, their patients and the MDT. Most importantly, the internal and external changes were sustained at follow-up and a higher percentage of the patients in treatment moved forward more rapidly to conditions of lower security than those in control. Music Therapists were able to use CAT mapping techniques with their patients when supervised by a CAT Supervisor.

The patient preference modification of the randomised controlled trial was feasible in the high secure hospital setting. This may be a context-specific outcome as patients in a high secure setting have limited choice, and unlike medium and low secure hospitals or prisons for offenders who have committed minor offences, most patients are resident over years rather than months. It is therefore in their interest to recover and to engage in treatment choices.

Qualitative examination for relationships between variables and the treatment effect, indicate that G-CAMT is a clinically effective intervention with treatment resistant, long-stay patients above the median age and above the median duration of offending history (14 years) and who have no prior experience of music therapy. The PROQ2 primary outcome measure is fit for purpose in its

detailed qualitative descriptions of relating thereby contributing to a mixed methods analysis. The lower domains and the upper domains provided fascinating information, which corresponded with the IPA analysis of patients' own descriptions of how they had changed.

The novel aspects of the manual in respect of LN results relating to victim empathy, shame and remorse make G-CAMT unique and different from a free floating psychodynamic approach. The results support the fundamental concepts of CAT as a treatment model in which the patients learn dialogically from the 'more experienced other' and the role of the music therapist in leading, guiding and advising. This aspect has nothing to do with age and everything to do with the music therapist's own ability to learn from the more experienced other, whether in supervision, through her own experiences or through learning and developing their own practice having initially adhered to the manual.

The findings of the present study may be interpreted with caution given the small sample size and the methodological difficulties of recruiting to and conducting a robust, mixed methods study within the confines and security restrictions of a high secure treatment setting. The results of combining mixed methods analysis of this partially randomised sample indicate that G-CAMT is a clinically effective versatile treatment model in keeping with the CAT tradition. The use of the sound print and the safety call were considered to be useful novel techniques within the forensic treatment setting. The findings indicate a need for future research on a larger sample across low, medium and high secure populations using this model and the treatment manual over different time-limited durations according to the treatment setting: eight, sixteen, twenty four or thirty two sessions.

Further research and reliable data collection is needed to conduct a study into the clinical and cost effectiveness of G-CAMT in reducing the overall length of stay (Table 9.1, 9.2), also examining the sustained effect which the intervention was shown to have at follow-up in the present study and whether this may sustain in the community. The manual could be used in community day care treatment settings towards maintaining the health of people suffering with severe and enduring mental illness as they transition towards normal conditions without the physical containment of the secure hospital systems. Separate studies are required to test the effectiveness G-CAMT with matched groups of patients with severe and dangerous personality disorder and those in the community with borderline personality disorder.

G-CAMT is true to a music therapy philosophy in which music therapists may develop their own musical styles within this treatment model, to match their patients' needs and their own musical skill set, having received guidance and advice on what works psychologically through the use of a

treatment manual. The G-CAMT treatment manual was shown to enable them to do so without undue anxiety, in a spirit of learning from the more experienced others who went before them. By building on this knowledge they avoided falling into the trap of repeating the mistakes and anxieties in music therapy treatment which had often occurred in secure hospital settings prior to the present study. By adhering to the overarching principles that are context specific to forensic MDT treatment and by following the G-CAMT manual, music therapists new to the forensic setting may feel confident in delivering a robust treatment which also gives them the space and freedom to build on their own creative innovations.

Postscript

When the Prophet Mohammed came, great stress was put on the idea of a formless God – made intelligible by His attributes, As Creator, as Father, as Mother, as Sustainer, as Judge, as Forgiver, as the Source and the Whole of manifestation, One who is always with His creature, within him, without him, Who notices all his feelings, thoughts and actions – before whom man must appear to give his account. (Khan 1979 p.215)

References

- Ablon, J.S. and Jones, E.E., 2002. Validity of controlled clinical trials of psychotherapy: findings from the NIMH Treatment of Depression Collaborative Research Programme. *American Journal of Psychiatry*, 159, pp.775–83.
- Adlam, J., Aiye buisi, A., Kleinot, P., Motz, A. and Scanlon, C., 2012. eds. *The therapeutic milieu under fire: security and insecurity in forensic mental health*. Forensic Focus 34. London: Jessica Kingsley Publications.
- Adler, A., 1930. *The science of living*. Reprint 2013. London: Routledge.
- Adler, A., 1964. *The individual psychology of Alfred Adler*. H.L. Ansbacher and R.R. Ansbacher, eds. New York: Harper Torchbooks.
- Adshead, G., 1988. ‘Written on the body’: deliberate self-harm and violence. In: E.V. Welldon and C. Velsun, ed. 1997. *A practical guide to forensic psychotherapy*. London: Jessica Kingsley Publications. pp.110-114.
- Adshead, G., 2003. More Alike than Different: Gender and Forensic Mental Health. In: N. Jeffcote and T. Watson, eds. 2004. *Working Therapeutically with Women in Secure Mental Health Settings*. London: Jessica Kingsley Publishers. pp.91-108.
- Adshead, G., 2012. ‘Mirror, mirror’: parallel processes in forensic institutions. In: J. Adlam, A. Aiye buisi, P. Kleinot, A. Motz and C. Scanlon, eds. 2012. *The therapeutic*

- milieu under fire: security and insecurity in forensic mental health*. Forensic Focus 34. London. Jessica Kingsley Publications. pp.97–116.
- Adshead, G., Sharmila, C. and Pyszoa, N., 2005. Moving on: a group of patients leaving a high secure hospital. *Group Analysis*, 38(3), pp.380–94.
- Aigen, K., 2005. *Music-centered music therapy*. Gilsum, NH: Barcelona Publishers.
- Aigen, K., 2012. Social interactions in jazz: implications for music therapy. *Nordic Journal of Music Therapy*, 22(3), pp.180-209.
- Aiyegbusi, A. 2012. Boundaries and boundary violations in the nurse-patient relationship with people diagnosed with personality disorders in DSPS and WEMSS: some findings from a mixed methods study. In: A. Aiyegbusi and G. Kelly, ed. 2012. *Professional and therapeutic boundaries in forensic mental health practice*. London: Jessica Kingsley Publishers. pp.137-157.
- Aiyegbusi, A. and Kelly, G., eds., 2012. *Professional and therapeutic boundaries in forensic mental health practice*. London: Jessica Kingsley Publications.
- Akande, R., 2007. A sign for the therapeutic relationship. *Reformulation*, 29, Winter issue, pp.6–7.
- Aldridge, D. and Fachner, J., 2006. *Music and altered states*. London: Jessica Kingsley Publications.
- Alvin, J., 1966. *Music therapy*. London: Stainer & Bell.
- American Music Therapy Association, 2013. *Music therapy definition*. Available at: <<http://www.musictherapy.org/about/musictherapy/>> [Accessed 4 May 2014].
- American Psychiatric Association, 2000. *The diagnostic and statistical manual of mental disorders (DSM-IV-TR)*. 4th ed. Washington, DC: American Psychiatric Association.
- Andreasen, N.C., Arndt, S., Alliger, R., Miller, D. and Flaum, M., 1995. Symptoms of schizophrenia: methods, meanings, and mechanisms. *Archives of General Psychiatry*, 52, pp.341–51.
- Andsell, G. and Pavlicevic, M., 2004. Guide to Music Therapy Research. *British Society of Music Therapy*. London: Jessica Kingsley Publishers.
- Annesley, P. and Jones, L., 2013. Care and control: delivering forensic psychological therapies in a high secure hospital setting. In: S.J. Compton Dickinson, H. Odell-Miller, and J. Adlam, eds. 2013. *Forensic music therapy: a treatment for men and women in secure hospital settings*. London: Jessica Kingsley Publishers pp.25-41.
- Anthony, W.A., 1993. Recovery from mental illness: the guiding vision of mental health systems in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), pp.11–23.

- Association of Cognitive Analytic Therapy (ACAT), 2014. *Annual conference*.
Available at: <<http://www.acat.me.uk/event/743/acat+annual+national+conference+2014-07-9.htm>> [Accessed 4 September 2014].
- Attkisson, C. and Greenfield, T., 1994. Satisfaction questionnaire-8 and service satisfaction scale 30. In: *Psychological testing: treatment planning and outcome assessment*, ed. 1994. San Francisco, CA: Lawrence Erlbaum Associates.
- Attkisson, C., Cook, J., Karno, M., Lehman, A., McGlashen, T.H., Meltzer, H.Y., O'Connor, M., Richardson, D., Rosenblatt, A., Wells, K. and Williams, J., 1992. Clinical services research. *Schizophrenia Bulletin*, 18, pp.561–626.
- Bakermans-Kranenburg, M.J. and van IJzendoorn, M.H., 2009. The first 10,000 adult attachment interviews: distribution of adult attachment representations in clinical and non-clinical groups. *Attachment and Human Development*, 11(3), pp.223–63.
- Balint, M., 1968. *The basic fault: therapeutic aspects of regression*. London: Tavistock Publications.
- Barkham, M., Evans, C., Margison, F., Mcgrath, G., Mellor-Clark, J., Milne, D. and Connell, J., 1998. The rationale for developing and implementing core outcome batteries for routine use in service settings and psychotherapy outcome research. *Journal of Mental Health*, 7, pp.35–47.
- Bartlett, A., 2009. Medical models of mental disorder. In: G. McGauley and A. Bartlett, eds. *Forensic mental health systems: concepts, systems, and practice*, ed. 2009. Oxford: Oxford University Press. Ch.2.
- Bateman, A. and Fonagy, P., 2001. Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. *American Journal of Psychiatry*, 158, pp.36–42.
- Bates, B., 2004. *The Way of Wyrd*. London: Book Club Associates/ Century Publishing Inc.
- Batson, C.D., Fultz, J. and Schoenrade, P.A., 1987. Distress and empathy: two qualitatively distinct vicarious emotions with different motivational consequences. *Journal of Personality*, 55(1), pp.19–39.
- Beck, A.T., 1970. Cognitive therapy: nature and relation to behaviour therapy. *Behaviour Therapy*, 1, pp.184–200.
- Beck, A.T., Steer, R.A. and Carbin, M.G., 1988. Psychometric properties of the Beck depression inventory: twenty-five years of evaluation. *Clinical Psychology Review*, 8(1), pp.77–100.
- Benjamin, L.S., 1974. Structural analysis of social behaviour. *Psychological Review*, 81, pp.392–425.
- Benjamin, L.S., 1987. Use of the SASB dimensional model to develop treatment plans for personality disorders: 1. Narcissism. *Journal of Personality Disorders*, 1, pp.43–70.

- Benjamin, L.S., Foster, S.W., Roberto, L.G. and Estroff, S.E., 1986. Breaking the family code: analysis of videotapes of family interactions by Structural Analysis of Social Behaviour (SASB). In: L.S. Greenberg and W.M. Pinsof, eds. *The psychotherapeutic process: a research handbook*, ed. 1986. New York: Guilford Press. pp.391–438, 741.
- Bennett, D., Kellett, S. and Ryle, A., (in press) *Cognitive Analytic Therapy for Borderline Personality Disorder: a process study and audit of the effectiveness of current practice*.
- Bennett, D. and Parry, G., 1998. The accuracy of reformulation in cognitive analytic therapy: a validation study. *Psychotherapy Research*, 8(1), pp.84–103.
- Bennett, D. and Parry, G., 2004. A measure of psychotherapeutic competence derived from cognitive analytic therapy. *Psychotherapy Research*, 14, pp. 176–192.
- Bennett, D., Parry, G. and Ryle, A., 2006. Resolving threats to the therapeutic alliance in cognitive analytic therapy of borderline personality disorder: a task analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 79, pp.395–418.
- Bennett, D., Pollock, P. and Ryle, A., 2005. The states description procedure: the use of guided self-reflection in the case formulation of patients with borderline personality disorder. *Clinical Psychology and Psychotherapy*, 12, pp.50–57.
- Bensimon, M., Tomer, E. and Avi, G., 2013. The impact of relaxing music on prisoners' levels of anxiety and anger. *International Journal of Offender Therapy and Comparative Criminology*. Advance online publication.
- Bilsbury, C.D. and Richman, A., 2002. A staging approach to measuring patient-centred subjective outcomes. *Acta Psychiatrica Scandinavica*, 106(4), p.5411.
- Birtchnell, J., 1993. *How humans relate: a new interpersonal theory*. Hove, UK: Psychology Press.
- Birtchnell, J., 1997. Attachment in an interpersonal context. *British Journal of Psychology*, 70, pp.265–79.
- Birtchnell, J., Denman, C. and Okhai, F., 2009. Cognitive analytic therapy: comparing two measures of improvement. *Psychology and Psychotherapy: Theory, Research and Practice*, 77(4), pp.479–92.
- Birtchnell, J. and Evans, C., 2004. The persons relating to others questionnaire. *Personality and Individual Differences*, 36, pp.125–40.
- Birtchnell, J. and Shine, J., 2000. Offence typology and the interpersonal octagon: an exploratory analysis. *Criminal Behaviour and Mental Health*, 2(2), pp.227–29.
- Birtchnell, J., Shuker, R., Newberry, M. and Duggan, C., 2009. An assessment of change in negative relating in two male forensic therapy samples using the persons relating to others questionnaire. *Journal of Forensic Psychiatry and Psychology*, 20(3), p.387–407.

- Bitsika, V. and Sharpley, C.F., 2006. Treating the client rather than the symptoms: moving beyond manualised treatments in psychotherapy. *Australian Journal of Guidance and Counselling*, 16(2), pp.159–75.
- Bittman, B., Dickson, L. and Coddington, K., 2009. Creative musical expression as a catalyst for quality-of-life improvement in inner-city adolescents placed in a court-referred residential treatment programme. *Advances in Mind-Body Medicine*, 24(1), pp.8–19.
- Blackburn, R., 1999. Relationship of personality disorders to observer ratings of interpersonal style in forensic psychiatric patients. *Journal of Clinical Forensic Medicine*, 6(1), p.56.
- Blackburn, R. and Glasgow, D., 2006. Manual for the chart of interpersonal reactions in closed living environments. Unpublished Manuscript. University of Liverpool.
- Blackburn, R. and Dolan, M., 2006. Interpersonal factors as predictors of disciplinary infractions in incarcerated personality disordered offenders. *Personality and Individual Differences*, 40(5) pp.897–907.
- Blackburn, R. and Renwick, S., 1996. Rating scales for measuring the interpersonal circle in forensic psychiatric patients. *Psychological Assessment*, 8, pp.76–84.
- Blood, A.J. and Zatorre, R.J., 2001. Intensely pleasurable responses to music correlate with activity in brain regions implicated in reward and emotion. *Proceedings of the National Academy of Sciences*, 98(1), pp.11818–23.
- Blunden, J., 2008. *Cognitive analytic supervisory training days*. Unpublished. : accessed on 20.11.14 at <http://www.acat.me.uk>
- Borignini, M., 2009. *The hawthorne effect and the overestimation of treatment effectiveness*. Available at:
<<http://www.psychologytoday.com/blog/overcoming-pain/201011/the-hawthorne-effect-and-the-overestimation-treatment-effectiveness>> [Accessed 12 May 2014].
- Bowlby, J., 1988. *A secure base: clinical applications of attachment theory*. Oxford: Routledge.
- Briere, J., 2002. *Multiscale dissociation inventory professional manual*. Odessa, FL: Psychological Assessment Resources.
- Briere, J., Weathers, F.W. and Runtz, M., 2005. Is dissociation a multidimensional construct? Data from the Multiscale Dissociation Inventory. *Journal of Traumatic Stress*, 18, pp.221 - 231.
- Brockman, B., Poynton, A., Ryle, A. and Watson, J.P., 1987. Effectiveness of time-limited therapy carried out by trainees: comparison of two methods. *British Journal of Psychiatry*, 151, pp.602–9.
- Brooks, R., 1996. EuroQol: the current state of play. *Health Policy*, 37, pp.53–72.

- Brown, G.W. and Harris, T., 1978. The Camberwell study: the origins of life events and difficulties. In: G.W. Brown and T.O. Harris. 1989. *Life events and illness*. New York: Guilford Press.
- Bruscia, K. 2002.A Psychodynamic Orientation to the Bonny Method in: Bruscia, K. and Groke, D., 2002.(eds.) *Guided imagery and music: the Bonny method and beyond*. Gilsum, NH: Barcelona Publishers.(pp225-243)
- Bruscia, K., 1987. *Improvisational models of music therapy*. Springfield, IL: Charles C. Thomas.
- Buch, E., 2013. Scandal at Le sacre: games of distinction and dreams of barbarism. In: H. Danuser and H. Zimmermann, eds. *Avatar of modernity: the Rite of Spring reconsidered*. Boosey and Hawkes London, UK.
- Bunt, L., 1994. *Music therapy: an art beyond words*. New York: Routledge.
- Butwell , B.A., Jamieson, E. and Leese, M. 2000. Trends in special (high-security) hospitals: residency and discharge episodes, 1986–1995. *British Journal of Psychiatry*, 176, pp 260–65.
- Byford, S., McCrone, P. and Barrett, B., 2003. Developments in the quantity and quality of economic evaluations of mental health. *Current Opinion in Psychiatry*, 16, pp.703–7.
- Byng, R. and Jones, R., 2004. Mental Health Link: the development and formative evaluation of a complex intervention to improve shared care for patients with long-term mental illness. *Journal of Evaluation in Clinical Practice*, 10(1), pp.27–36.
- Byng, R., Jones, R., Leese, M., Hamilton, B., McCrone, P. and Craig, T., 2004. Exploratory cluster randomised controlled trial of shared care development for long-term mental illness. *British Journal General Practice*, 54(501), pp.259-66.
- Campbell, M., Fitzpatrick, R. and Haines, A., 2000. Framework for design and evaluation of complex interventions to improve health. *British Medical Journal*, 321, pp.694–96.
- Campbell, N.C., Murray, E. and Darbyshire, J., 2007. Designing and evaluating complex interventions to improve health care. *British Medical Journal*, 334, pp.455–59.
- Carr, C., d’Ardenne, P., Sloboda, A., Scott, C., Wang, D. and Priebe, S., 2012. Group music therapy for patients with persistent post-traumatic stress disorder – an exploratory randomised controlled trial with mixed methods evaluation. *Psychology and Psychotherapy*, 85(2), pp.179–202.
- Carr, C., Odell-Miller, H. and Priebe, S., 2013. A systematic review of music therapy practice and outcomes with acute adult psychiatric in-patients. *PLoS ONE*, 8(8).
- Casement, P., 1985. *On learning from the patient*. London and New York: Tavistock Publications Ltd.

- Casement, P., 2014. *On further learning from the patient: the analytic space and process*. Hove, UK: Routledge.
- Chanen, A.M., Jackson, H., McCutcheon, L.K., Joveve, M., Dudgeon, P., Yuen, H.P., ermano, D., McDougall, E. and McGorry, P.D., 2008. Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: randomised controlled trial. *British Journal of Psychiatry*, 193, pp.477–84.
- Chanen, A.M., Jackson, H.J., McCutcheon, L.K., Jovev, M., Dudgeon, P., Yuen, H.P., Germano, D., Nistico, H., McDougall, E., Weinstein, C., Clarkson, V. and McGorry, P.D. 2009b. Early intervention for adolescents with borderline personality disorder: quasi-experimental comparison with treatment as usual. *Australian and New Zealand Journal of Psychiatry*, 43, pp.397–408.
- Chanen, A.M., McCutcheon, L., Germano, D., Nistico, H., Jackson, H.J. and McGorry, P.D., 2009a. The HYPE Clinic: an early intervention service for borderline personality disorder. *Journal of Psychiatric Practice*, 15, pp.163–72.
- Chanen, A., McGorry, P. and Jackson, H., 2008. *Indicated prevention and early intervention for borderline personality disorder in the music therapistng people*. Cambridge: Cambridge University Press.
- Chen, X.J., Niels, H., Xu, N. and Gold, C., 2013. Group music therapy for prisoners: protocol for a randomised controlled trial. *Nordic Journal of Music Therapy*, 23(3), pp.224-241.
- Clarke, S., Thomas, P. and James, K., 2013. Cognitive analytic therapy for personality disorder: randomised controlled trial. *British Journal of Psychiatry: The Journal of Mental Science*, 202, pp.129–34.
- Cleckley, H.M., 1941. *The mask of sanity: an attempt to clarify some issues about the so-called psychopathic personality*. St. Louis, USA. Mosby Medical Library. ISBN 0-452-25341-1
- Clifford, P., 1998. M is for outcome: the CORE outcomes initiative. *Journal of Mental Health*, 7, pp.19–24.
- Coe, J. and Gabbard, G., 2012. Boundary violations: are transgressing professionals beyond help? In: A. Aiyegbusi and G. Kelly, eds. 2012. *Professional and therapeutic boundaries in forensic mental health practice*. London: Jessica Kingsley Publishers. pp. 43-53.
- Coid, J., Kahtan, N., Gault, S. and Jarman, B., 2000. Women admitted to secure forensic psychiatry services. *Journal of Forensic Psychiatry*, 11(2), pp.275-295.
- Compton Dickinson, S.J., 2001a. *Compare and contrast the practice of CAT with dynamic psychotherapy*. King's College Library: Academic Psychiatry, Guys Campus and Institute of Psychiatry Library.
- Compton Dickinson, S.J., 2001b. *A case of work, rest and play: music therapy in early psychosis* In: S.J. Compton Dickinson, H. Odell-Miller, and J. Adlam, eds. 2013. *Forensic music*

- therapy: a treatment for men and women in secure hospital settings*. London: Jessica Kingsley Publishers (or available from the author)
- Compton Dickinson, S.J., 2002. *MSc project report: a comparative study between time limited CAT and time limited psychodynamic therapy*. King's College Library: Academic Psychiatry, Guys Campus and Institute of Psychiatry Library.
- Compton Dickinson, S.J., 2003a *Community, culture and conflict: the role of creativity*. London: British Society of Music Therapy Publications.
- Compton Dickinson, S.J., 2003b. What are the most dominant roles in society? A reflection on the issues that may engender these particular reciprocal roles and how they may manifest within CAT with individual patients. Unpublished. ACAT Practitioner Accreditation Training St Thomas' Hospital. Available by request to: www.stellacompton.co.uk.
- Compton Dickinson, S.J., 2004. Community, culture and conflict. Part 2: Changes. *Music Therapy Today*, 5(5).
- Compton Dickinson, S.J., 2006. Beyond body, beyond words: cognitive analytic music therapy in forensic psychiatry - new approaches in the treatment of personality disordered offenders. *Music Therapy Today*, 7(4), pp.839–75.
- Compton Dickinson, S.J. and Beeley, C. *Music therapy patient satisfaction questionnaire*. Unpublished. Available from Victoria Sleight: The Arts Therapies Department, High Secure Forensic Services, Nottinghamshire Healthcare NHS Trust.
- Compton Dickinson, S.J. and Benn, A., 2012. Discovering harmony: music therapy in forensic settings. In: A. Aiyegbusi and G. Kelly, eds. *Professional and therapeutic boundaries in forensic mental health practice*. London: Jessica Kingsley Publishers. pp.87–101.
- Compton Dickinson, S.J., Gahir, M., 2013. Working with conflict: a summary of developments of a man suffering with paranoid schizophrenia, who committed manslaughter. In: S.J. Compton Dickinson, H. Odell-Miller and J. Adlam, eds. 2013. *Forensic music therapy: a treatment for men and women in secure hospital settings*. London: Jessica Kingsley Publishers. Ch.7.
- Compton Dickinson, S.J., 2013. "The lost boy": an exploration of dissociation using Cognitive Analytic Music Therapy. In: S. Compton Dickinson, H. Odell-Miller and J. Adlam, eds. 2013. *Forensic Music Therapy: a treatment for men and women in secure hospital settings*. London: Jessica Kingsley Publishers. Ch.9.
- Compton Dickinson, S.J., Odell-Miller, H. and Adlam, J., eds., 2013. *Forensic music therapy: a treatment for men and women in secure hospital settings*. London: Jessica Kingsley Publishers
- Compton Dickinson, S.J., Odell-Miller, H. and McGauley, G., (in press) Manualised music therapy: the research and development of an integrated model for multi-disciplinary

- treatment pathways for the treatment of in-patients with severe mental disorders, in secure hospitals. *International Journal of Applied Psychoanalytic Studies*. (Special edition to be published March 2015).
- Compton Dickinson, S. J. and Souflas, P., 2012. Rapping round the system: a young black man's journey through high secure treatment. In: S. Hadley and G. Yancy, eds. 2012. *Therapeutic uses of rap and hip hop*. New York: Routledge. pp.353–73.
- Cordess, C. and Cox, C., 2004. *Forensic psychotherapy, crime, psychodynamics and the offender patient*. 2 vols. London: Jessica Kingsley Publishers.
- Costa, P.T. Jr. and Widiger, T.A., eds. 1994. *Personality disorders and the five-factor model of personality*. Washington DC: American Psychological Association. (1994)
- Cox, A. and Gelsthorpe, L., 2008. *Beats & bars, music in prisons: an evaluation*. Cambridge: Institute of Criminology.
- Craig, P., Dieppe, P., Macintyre, E.S., Michie, S., Nazareth, I. and Petticrew, M., 2008. Developing and evaluating complex interventions: the new Medical Research Council guidance. *British Medical Journal*, 337 (7676), pp.979–83.
- Crawford, M.J. and Patterson, S., 2007. Arts therapies for people with schizophrenia: an emerging evidence base. *Evidence Based Mental Health*, 10, pp.69–70.
- Cresswell, J.W., 2003. Research design: qualitative, quantitative and mixed methods approaches. Thousand oaks C.A. , London, New Delhi, Sage Publications
- Crotty, M., 1998. The foundations of social research : meaning and perspective in the research process. London: Sage Publications.
- Crimmens, A., 2012. *Identifying and quantifying music therapy services within a forensic psychiatric setting serving residents with aggressive and criminal behaviour*. Charleston, USA: ProQuest, UMI Dissertation Publishing.
- Davidson, K.M. and Tyrer, P., 1996. Cognitive therapy for antisocial and borderline personality disorders: single case study series. *British Journal of Clinical Psychology*, 35, pp.413–29.
- Davies, A. and Richards, E., 2002. *Music therapy and group work*. London: Jessica Kingsley Publishers.
- Davies, A., Richards, E. and Barwick, N., 2014. *Group music therapy: a group analytic approach*. New York: Routledge.
- Daykin, N., De Viggiani, N., Pilkington, P. and Moriarty, Y., 2013. Music making for health, well-being and behaviour change in youth justice settings: a systematic review. *Health Promotion International*, 28(2), pp.197–29.
- Dell, S. and Robinson, G., 1988. *Sentenced in hospital: offenders in Broadmoor*. Maudsley Monographs. Oxford: Oxford University Press.

- Department of Health, 1999. *Modernising health and social services: national priorities guidance*. [online] Available at:
<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4004549> [Accessed 14 September 2014].
- Department of Health, 2000. *Race Relations (Amendment) Act*. [online] Available at:
<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managing your organisation/Equalityandhumanrights/Raceequality/DH_4135737> [Accessed 22 September 2014].
- Department of Health, 2001. Commissioning in the new NHS – specialist commissioning of high and medium security psychiatric services. *Health and Social Care*, 99(141).
- Devereux, D., 2012. The patient's experience of professional abuse in the psychological therapies. In: A. Aiyegbusi and G. Kelly, eds. 2012. *Professional and therapeutic boundaries in forensic mental health practice*. London: Jessica Kingsley Publishers. pp.33–43.
- De Backer, J. and Sutton, J., 2014. *The music in music therapy - psychodynamic music therapy in Europe: clinical, theoretical and research approaches*. London: Jessica Kingsley Publishers.
- De Viggiani, N., Macintosh, S. and Lang, P., 2009. *Music in time: an evaluation of a participatory creative music programme for older prisoners*. [pdf] Project Report. Bristol: University of the West of England. Available at: <<http://eprints.uwe.ac.uk/8255/>> [Accessed on 22 September 2014].
- Digard, L., Von Sponeck, A. and Liebling, A., 2007. All together now: the therapeutic potential of a prison-based music programme. *Prison Service Journal*, 170 (March), pp.3–14.
- Doctor, R., 2008. *Murder: a psychotherapeutic investigation*. London: Karnac Books.
- Dostoyevsky, F., 1886. *Crime and Punishment*. London: Penguin Books.
- Dozier, M., Lomax, L., Tyrell, C. and Lee, S., 2001. The challenge of treatment for clients with a dismissing state of mind. *Attachment and Human Behaviour*, 3(1), pp.62–76.
- Drake, R.E., Goldman, H.H., Leff, S., Lehman, A.F., Dixon, L., Mueser, K.T., Torrey, W.C., 2001. Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services*, 52(2), pp.179-82.
- Duggan, C., Adams, C., McCarthy, L., Fenton, M., Lee, T., Binks, C. and Stocker, O., 2006. *A systematic review of the effectiveness of pharmacological and psychological treatments for those with personality disorder*. Nottinghamshire Healthcare NHS Trust Institute of Mental Health. Available at:
<<http://www.nfmhp.org.uk/MRD%2012%2033%20Final%20Report.pdf>> [Accessed on 21 July 2014].

- Eisenberg, N. and Strayer, J., 1988. *Empathy and its development*. Cambridge: Cambridge University Press.
- Ellis, A., 1962. *Reason and emotion in psychotherapy*. New York: Lyle Stuart.
- Erkkila, J., Punkanen, M., and Fachner, J., 2011. Individual music therapy for depression: randomised controlled trial. *British Journal of Psychiatry; the journal of mental science* 2011 Aug;199(2):132-9.
- Evans, C., Connell, J., Barkham, M., Marshall, C. and Mellor-Clark, J., 2003. Practice-based evidence: benchmarking NHS primary care counselling services at national and local levels. *Clinical Psychology and Psychotherapy*, 10, pp.374–88.
- Evans, C., Dolan, D. and Norton, K., 1995. Multiple axis-11 diagnoses of personality disorder. *British Journal of Psychiatry*, 166, pp.107–12.
- Fachner, J., 2009. Music and altered states of consciousness: an overview. In: D. Aldridge and J. Fachner, eds. 2009. *Music and altered states*. London: Jessica Kingsley Publishers. Ch.2.
- Fay, M.P. and Proschan, M.A., 209. Wilcoxon–Mann–Whitney or t-test? On assumptions for hypothesis tests and multiple interpretations of decision rules. *Statistics Surveys*, 4, pp.1–39.
- Feshbach, N.D. 1978. Studies of empathic behaviour in children. In: B.A. Maher, ed. 1978. *Progress in experimental personality research*. New York: Academic Press. Vol.8, pp.1–47.
- Foulkes, S.H., 1964. *Therapeutic group analysis*. Reprint 1984. London: Karnac Books.
- Freud, S., 199. The future prospect of psychoanalytic therapy. In: J. Strachey, ed. 199. *The standard edition of complete works of Siegmund Freud*. London: Hogarth Press. pp.139–151.
- Freud, S. and Breuer, J., 1991. *On studies in hysteria 1893–1895*. London, UK: Penguin Books.
- George, C. and Solomon, J., 1996. Representational models of relationships: links between care giving and attachment. *Infant Mental Health Journal*, 17, pp.198–216.
- Glorney, E., Perkins, P., Adshead, G., McGauley, G.A., Noak, J., Murray, K. and Sichau, G., 209. Reducing length of stay in high secure hospital settings: a model for streamlining care in Broadmoor Hospital. *The International Journal of Forensic Mental Health*, 9, pp.138–48.
- Glyn, J., 2002. Drummed out of mind – a music therapy group with forensic patients. In: A. Davies and E. Richards, eds. 2002. *Music therapy and group work*. London: Jessica Kingsley Publishers.
- Glyn, J., 2009. Two’s company, three’s a crowd. In: H. Odell-Miller and E. Richards, eds. 2009. *Supervision of music therapy: a theoretical and practical handbook*. London and New York: Routledge. pp.67–82.

- Goffman, E., 1961. *Asylums: essays on the social situation of mental patients and other inmates*. Garden City, NY: Anchor Books.
- Gold, C., Assmus, J., Hjørnevik, K., Qvale, L.G., Brown, F.K., Hansen, A.L., Waage, L. and Stige, B., 2014. Music therapy for prisoners: pilot randomised controlled trial and implications for evaluating psychosocial interventions. *International Journal of Offender Therapy and Comparative Criminology*, 58(12), pp.1520-39.
- Gold, C., Heldal, T.O., Dahle, T. and Wigram, T., 2005. Music therapy for schizophrenia-like illnesses. *The Cochrane Database of Systemic Reviews*, [online] 2 (CD14004025) Available at <<http://onlinelibrary.wiley.com/doi/9.1002/14651858.CD004025.pub2/abstract>>.
- Gold, C., Mössler, K., Grocke, D., Heldal, T.O., Tjemsland, L., Aarre, T., Aaro, L.E., Rittmannsberger, H., Stige, B., Assmus, J. and Rolvsjord, R., 2013. Individual music therapy for mental health care clients with low therapy motivation: multicentre randomised controlled trial. *Psychotherapy and Psychosomatics*, 82(5), pp.319–31.
- Gold, C., Solli, H.P., Krueger, V. and Lie, S.A., 2009. Dose-response relationship in music therapy for people with serious mental disorders: systematic review and meta-analysis. *Clinical Psychology Review*, 29(3), pp.193–207.
- Gold, C., Wigram, T. and Voracek, M., 2004. Effects of music therapy for children and adolescents with psychopathology: a meta-analysis. *Journal of Child Psychology and Psychiatry*, 45(6), pp.1054–63.
- Gomez, L., 1997. *An introduction to object relations theory*. London: Free Association Press.
- Greenberg, L.S., 1984. A task analysis: the general approach. In: L.N. Rice and L.S. Greenberg, eds. 1984. *Patterns of change: the intensive analysis of psychotherapy process*. New York: Guilford Press. pp.67–123.
- Greenfield, T.K., and Attkisson, C.C., 1983. *Client satisfaction questionnaire: the Dutch experience*. *Evaluation and Programme Planning*, 6, pp.395–400.
- Haakvoort, L., 2002. A music therapy anger management programme for forensic offenders. *Music Therapy Perspectives*, 20(2), pp.123–32.
- Haakvoort, L., 2014. Multifaceted music therapy in forensic psychiatry. In: J. de Backer and J. Sutton, eds. 2014. *The music in music therapy- psychodynamic music therapy in Europe: clinical, theoretical and research approaches*. London: Jessica Kingsley Publishers. Ch.9.
- Hannibal, N., 2003. A woman's change from being nobody to somebody: music therapy with a middle-aged, speechless and self-destructive woman. In: S. Hadley, ed. 2003. *Music therapy: case studies*. Phoenixville, PA: Barcelona Publishers. pp.403-414.
- Hannibal, N., 2014. Implicit and explicit mentalisation in music therapy in the psychiatric treatment of people with borderline personality disorder. In: J. de Backer and J. Sutton, eds.

2014. *The music in music therapy- psychodynamic music therapy in Europe: clinical, theoretical and research approaches*. London: Jessica Kingsley Publishers. Ch.14.
- Hartley, N., 1999. Music therapist's personal reflections on working with those who are living with HIV/ AIDS. In: D. Aldridge, ed. 1999. *Music therapy in palliative care: new voices*. London: Jessica Kingsley Publishers. pp.105-124.
- Harty, A.M., Shaw, J. Thomas, S., Dolan, M., Davies, L., Thornicroft, G., Carlisle, J., Moreno, M., Leese, M., Appleby, L. and Jones, P. 2004. The security, clinical and social needs of patients in high security psychiatric hospitals in England. *Journal of Forensic Psychiatry and Psychology*, 15(2), pp.208–21.
- Hatton, C. and Taylor, J.L., 2005. Promoting healthy lifestyles: mental health and illness. In: G. Grant, P. Goward, M. Richardson and P. Ramcharan, eds. 2005. *Learning disability: a life cycle approach to valuing people*. Maidenhead: Open University Press. pp.559–603.
- Heal, M. and Wigram, T., 1993. *Music therapy in health and education*. London: Jessica Kingsley Publishers.
- Hervey, P. and Odell-Miller, H., 2013. Containment or contamination?: music therapy, personality disorder and the forensic mental health team. In: S.J. Compton Dickinson, H. Odell-Miller and J. Adlam, eds. 2013. *Forensic music therapy: a treatment for men and women in secure hospital settings*. London: Jessica Kingsley Publishers. Ch.12.
- Hewett, I., 2013. Did the Rite of Spring really spark a riot? *BBC News Magazine*. [online] Available at: <<http://www.bbc.co.uk/news/magazine-22691267>> [Accessed 11 September 2014].
- Hildebrand, M. and De Ruiter, C., 2012. Psychopathic traits and change on indicators of dynamic risk factors during inpatient forensic psychiatric treatment. *International Journal of Law and Psychiatry*, 35(4), p.276(13).
- Home Office, 2009. *The Macpherson report – ten years on*. Available at: <<http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhaff/427/42703.htm>> [Accessed_28 June 2014].
- Horvath, A.O. and Greenberg, L.S., 1989. Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, 36(2), pp.223–33.
- Horvath, A.O. and Symonds, B.D., 1991. Relation between working alliance and outcome in psychotherapy: a meta-analysis. *Journal of Counseling Psychology*, 38(2), pp.139–49.
- Hubbuck, J., 2008. The States Description Procedure. *Reformulation*, Summer issue, pp.46–53.
- Hughes, P. and Cormac, I., 2013. Music therapy with long-stay in-patients: communication issues and collaboration with the clinical team. In: S.J. Compton Dickinson, H. Odell-Miller and

- J. Adlam, eds. 2013. *Forensic music therapy: a treatment for men and women in secure hospital settings*. London: Jessica Kingsley Publishers. Ch.3.
- Hunot, V., Moore, T.H.M., Caldwell, D., Davies, P., Jones, H., Lewis, G. and Churchill, R., 2009. Interpersonal, cognitive analytic and other integrative therapies versus other psychological therapies for depression (protocol). *Cochrane Database of Systematic Reviews*, [online] 9 (CD008703) Available at <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4110712/>> [Accessed 31 March 2014].
- International Association for Forensic Psychotherapy (IAFP). Available at: <<http://forensicpsychotherapy.com>> [Accessed on 4 September 2014].
- Jolliffe, D. and Farrington, D.P., 2006a. Development and validation of the Basic Empathy Scale. *Journal of Adolescence*, 29(4), pp.589–611.
- Jolliffe, D. and Farrington, D.P., 2006b. Examining the relationship between low empathy and bullying. *Aggressive Behaviour*, 32(6), pp.540–50.
- Jones, L., 2004. Offence Paralleling Behaviour (OPB) as a framework for assessment and interventions with offenders. In: A. Needs and G. Towl, eds. 2004. *Applying psychology to forensic practice*. Oxford: Blackwell Publishing Ltd. pp.34–63.
- Jones, S.H., Thornicroft, G., Coffey, M. and Dunn, G., 1995. A brief mental health outcome scale-reliability and validity of the Global Assessment of Functioning (GAF). *British Journal of Psychiatry*, 166(5), pp.654–59.
- Jung, C.G., 1960. *The structure and dynamics of the psyche, collected works, Volume 8*. Princeton, NJ: Princeton University Press.
- Kabacoff, R., 2014. *Quick-R: accessing the power of R*. [online] Available at: <<http://www.statmethods.net>> [Accessed 21 September 2014].
- Kahr, B., 2008. Series foreword. In: R. Doctor, ed. 2008. *Murder: a psychotherapeutic investigation*. London: Karnac Books. Pps. ix–xii
- Kay, S.R., Fiszbein, A. and Opfer, L.A., 1987. The Positive and Negative Syndrome Scale (PANSS) for schizophrenia. *Schizophrenia Bulletin*, 13(2), pp. 261–76.
- Kaye, T., 2014. A one day workshop with Sounding Bowls: Sounding Bowls, talk & workshop with Tobias Kaye. Information available at: <<http://www.bamt.org/DB/events/sounding-bowls-talk-and-workshop-with-tobias-kaye.html>> [Accessed on 6 September 2014].
- Keating, F., Robertson, D., McCulloch, A. and Francis, E., 2002. *Breaking the circles of fear: a review of the relationship between mental health services and African and Caribbean communities*. London: Sainsbury Centre for Mental Health.

- Kellett, S., 2005. The treatment of Dissociative Identity Disorder (DIDS) with cognitive analytic therapy: experimental evidence of sudden gains. *Journal of Trauma and Dissociation*, 6(3), pp.55–81.
- Kellett, S., 2007. A time series evaluation of the treatment of histrionic personality disorder with cognitive analytic therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 80, pp.389–405.
- Kerr, I., 2002. Vygotsky, activity theory and the therapeutic community: a further paradigm? *Therapeutic Communities*, 21(3), pp.151-164.
- Kerr, I., Parry, G., Pickvance, D. and Turner, J., (in press) A cognitive analytic therapy (CAT)-based skills level training in working with ‘difficult’ and personality-disordered patients for generic community mental health team workers: rationale and description of training package.
- Khan, H.I., 1979. *The unity of religious ideals*. New Lebanon, NY: Sufi Order Publications. pp.215.
- Kiesler, D.J., 1983. The 1982 interpersonal circle: a taxonomy for complementarity in human transactions. *Psychological Review*, 90, pp.185–214.
- Kirkup, B. and Marshall, P., 2014. *Jimmy Savile investigation: Broadmoor Hospital. Report to the West London Mental Health NHS Trust and the Department of Health*. . [pdf] Available at:
<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323458/Broadmoor_report.pdf> [Accessed 14 September 2014].
- Klein, M., 1959. Our adult world and its roots in infancy. In: M. Klein, ed. 1975. *Envy and Gratitude and other works*. London: Vintage Press. Ch.12.
- Kurtz, A. and Turner, K., 2005. The needs of staff who care for offenders with a diagnosis of personality disorder who are considered a risk to others. *The Journal of Forensic Psychiatry and Psychology*, 16, pp.399–422.
- Laerd Statistics, 2014. *Friedman test in SPSS*. [online] Available at:
<<https://statistics.laerd.com/spss-tutorials/friedman-test-using-spss-statistics.php>> [Accessed 21 September 2014].
- Lapworth, P., Sills, C. and Fish, S., 2009. *Integration in counselling & psychotherapy: developing a personal approach*. London: Sage Publications.
- Larsen, D.L., Attkisson, C.C., Hargreaves, W.A., Nguyen, T.D., 1979. Assessment of client/patient satisfaction: Development of a general scale, *Evaluation and Program Planning*. (2), pp.197-207
- Lawday, R. and Compton, S.J. 2013. Integrating models for integrated care pathways. In: S. Compton Dickinson, H. Odell-Miller and J. Adlam, eds. 2013. *Forensic Music Therapy: a*

- treatment for men and women in secure hospital settings*. London: Jessica Kingsley Publishers. Ch.9.
- Leach, C., Lucock, M., Iveson, S. and Noble, R., 2004. Evaluating psychological therapies services: a review of outcome measures and their utility. *Mental Health and Learning Disabilities Research and Practice*, 1(1), pp.53–66.
- Leary, T., 1957. *Interpersonal diagnosis of personality: a functional theory and methodology for personality evaluation*. New York: Ronald Press.
- Lee, C., 2000. A method of analyzing improvisations in music therapy. *Journal of Music Therapy*, 37(2), pp.147–67.
- Lee, J.H., 1999. *The treatment of psychopathic and antisocial personality disorders: a review*. London: Risk Assessment Management and Audit Systems, Broadmoor Hospital.
- Leese, M.I., Thornicroft, G., Shaw, J., Thomas, S., Mohan, R., Harty, M.A. and Dolan, M., 2006. Ethnic differences among patients in high-security psychiatric hospitals in England. *British Journal of Psychiatry*, 188, pp.380–85.
- Leith, H., 2014. PhD thesis: Music therapy re-settlement of women prisoners. Aalborg University, Institute for communication, Music Therapy. Humanities Dept. Available at: http://vbn.aau.dk/files/204733924/Leith_2014_PhD_thesis_MT_RESETTLEMENT_WOMEN_PRISONERS.pdf > [Accessed on 15 November 2014].
- Linehan, M., 1993. *Skills training manual for treating borderline personality disorder*. New York: Guildford Press.
- Liotti, G. and Gumley, A., 2008. An attachment perspective on schizophrenia: the role of disorganized attachment, dissociation and mentalization. In: A. Moskowitz, I. Schafer and M.J. Dorahy, eds. 2008. *Psychosis, trauma and dissociation: emerging perspectives on severe psychopathology*. Chichester: John Wiley and Sons. Ch.9.
- Lister, H., 2012. *Validation of the 'Victim Empathy Response Assessment (ii)' (VERA-ii) with a non-offending adult male community sample*. [pdf] Available at: https://kclpure.kcl.ac.uk/portal/files/12936404/Studentthesis-Helen_Lister_2012.pdf > [Accessed 11 August 2014].
- Livesley, W.J., 2003. *Practical management of personality disorder*. London and New York: Guildford Press.
- Lodrick, Z., 2007. Psychological trauma – what every trauma worker should know. *The British Journal of Psychotherapy Integration*, 4(2), pp.1-19.
- Low, G., Terry, G., Duggan, C., MacLead, A. and Power, M., 1997. Deliberate self-harm among female patients at a special hospital: an incident study. *Health Trends*, 29(1), pp.6-9.

- Luborsky, L., Barber, J.P. and Crits-Christoph, P.A., 1995. Comparison of core conflictual relationship themes before psychotherapy and during early sessions. *Journal of Consulting and Clinical Psychology*, 63(1), pp.145–48.
- Lyne, J., Renwick, L., Grant, T., Kinsella, A., McCarthy, P., Malone, K., Turner, N., O’Callaghan, E. and Clarke, M., 2013. Scale for the assessment of negative symptoms structure in first episode psychosis. *Psychiatry Research*, 210(3), pp.1191–97.
- Macdiarmid, D., 1996. Course notes: dynamic psychotherapy. *MSc. Mental Health Studies*. King’s College London, Guy’s Hospital Campus, unpublished.
- Maden, T., 2005. Dangerous and severe personality disorder: clinical and legal implications. *Journal of Psychiatry*, 4(3), pp.23-25.
- Maguire, A. and Merrick, I., 2013. Walking the line: music therapy in the context of the recovery approach in a high secure hospital. In: S.J. Compton Dickinson, H. Odell-Miller and J. Adlam, eds. 2013. *Forensic music therapy: a treatment for men and women in secure treatment settings*. London: Jessica Kingsley Publishers. pp.104–20.
- Main, T., 1957. The ailment. *British Journal of Medical Psychology*, 30, pp.129–45.
- Mander, G., 2000. *A psychodynamic approach to brief therapy*. London: Sage Publications.
- Maratos, A., Gold, C., Wang, X. and Crawford, M., 2008. Music therapy for depression. *Cochrane Database of Systematic Reviews*, [online] 1 (CD004517) Available at < <http://onlinelibrary.wiley.com/doi/9.1002/14651858.CD004517.pub2/abstract> > [Accessed 14 April 2014].
- Margison, F.R., Markham, M., Evans, C., McGrath, G., Mellor Clark, J., Audin, K. and Connell, J., 2000. Measurement in psychotherapy: evidence-based practice and practice-based evidence. *British Journal of Psychiatry*, 177, pp.123–30.
- Martens, W.H.J., 2002. The hidden suffering of the psychopath. *Psychiatric Times*, 19(1), pp.1-7.
- Martin, D., Garske, J. and Davis, M., 2000. Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68, pp.438–50.
- McCaffrey, T., Edwards, J., Fannon, D., 2011. Is there a role for music therapy in the recovery approach in mental health? *The Arts in Psychotherapy Journal* pp. 185-189
- McCarney, R., Warner, J., Iliffe, S., van Haselen, R., Griffin, M. and Fisher, P., 2007. The Hawthorne effect: a randomised, controlled trial. *BMC Medical Research Methodology*, 7(1), pp.30-8.
- McGauley, G., 2009. Introduction to the psychotherapies for mentally disordered offenders. In: G. McGauley and A. Bartlett, eds. 2009. *Forensic mental health systems: concepts, systems, and practice*. Oxford: Oxford University Press. Ch.9.
- McGauley, G. and Bartlett, A., 2009. *Forensic mental health systems: concepts, systems, and*

- practice*. Oxford: Oxford University Press.
- McGauley, G. and Humphrey, M., 2003. Contribution of forensic psychotherapy to the care of forensic patients. *Advances in Psychiatric Treatment*, 9, pp.117–24.
- McGlashan, T.H. and Fenton, W.S., 1992. The positive-negative distinction in schizophrenia. Review of natural history validators. *Archives of General Psychiatry*, 49, pp.63–72.
- McGuire, J., 2000. *Offender rehabilitation and treatment: effective programmes and policies to reduce offending*. Chichester: John Wiley & Sons Ltd.
- McMurran, M., 2006. *Expert paper. NHS programme on forensic mental health research and development*. The Department of Health. Available from Nottinghamshire Healthcare NHS Trust
- Mears, D.T. and Watson, J., 2006. Towards a fair and balanced assessment of supermax prisons. *Justice Quarterly*, 23(2), pp.232–66.
- Menzies Lyth, I.E.P., 1960. A case-study in the functioning of social systems as a defence against anxiety: a report on a study of the nursing service of a general hospital. *Human Relations*, 13, pp.95-121.
- Milev, P., Ho, B.C., Arndt, S. and Andreasen, N.C., 2005. Predictive values of neurocognition and negative symptoms on functional outcome in schizophrenia: a longitudinal first-episode study with 7-year follow-up. *American Journal of Psychiatry*, 162(2005), pp.495–506.
- Ministry of Justice, 2009. *Proven re-offending statistics, definition and measurements*. [pdf] Ministry of Justice. Available at: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/218471/proven-reoffending-definition-measurement-260112.pdf> [Accessed 28 June 2014].
- Mitchell, J.A., 2006. Symptoms of dissociation in a forensic population. *Journal of Orthomolecular Medicine*, 21(2), pp.85–94.
- Moellenhoff, F., 1966. Hans Sachs, 1881–1947: the creative unconscious. In: F. Alexander, S., eds. 1966. Eisenstein and M. Grotjahn, eds. *Psychoanalytic pioneers*. New York: Basic Books. pp.180–99.
- Morrison, K.H., Bradley, R. and Westen, D., 2003. The external validity of controlled clinical trials of psychotherapy for depression and anxiety: a naturalistic study. *Psychology and Psychotherapy: Theory, Research and Practice*, 76, pp.109–32.
- Mössler, K., Chen, X., Heldal, T.O. and Gold, C., 2011. Music therapy for people with schizophrenia and schizophrenia-like disorders. *Cochrane Database of Systematic Reviews*, [online] 12 (CD004025) Available at <

<http://onlinelibrary.wiley.com/store/9.1002/14651858.CD004025.pub3/asset/CD004025.pdf?v=1&t=i2ou3i5h&s=f046b6a87ecd922c764dfefd1c12db616a38d8cd>].

Motz, A., 2008. *The psychology of female violence*. Hove, East Sussex: Routledge.

National Collaborating Centre for Mental Health (NCCMH), 1999. *NICE guidance for treatment and management of BPD 1999*. Royal College of Psychiatrists and British Psychological Service.

National Health Service (NHS) Institute for Innovation and Improvement, 2008. *Length of stay – reducing length of stay*. Paper available at:
<http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/length_of_stay.html> [Accessed 19 May 2014].

National Health Service (NHS) Knowledge and Skills Framework, 2004. *Skills for Health (2007) – CHS52 Plan inter-disciplinary assessment of the health and well-being of individuals*. Available at: <<http://www.wales.nhs.uk/sitesplus/829/opendoc/116851>> [Accessed 26 August 2014].

National Institute for Health and Care Excellence, 2003. *ASPD scoping table*. [pdf] National Institute for Health and Care. Available at:
<<http://www.nice.org.uk/nicemedia/live/11650/34428/34428.pdf>>.

National Institute for Health and Care Excellence, 2007. *Antisocial personality disorders scope consultation table*. [pdf] National Institute for Health and Care. Available at:
<<http://www.nice.org.uk/nicemedia/pdf/ASPDConsultationScopeTable.pdf>> [Accessed 9 August 2014].

National Institute for Health and Care Excellence, 2009. *NICE guidelines: schizophrenia*. [pdf] National Institute for Health and Care. Available at:
<<http://www.nice.org.uk/nicemedia/live/11786/43608/43608.pdf>> [Accessed 26 April 2014].

National Institute for Health and Care Excellence, 2009. *Guidelines set to improve treatment and management of people with antisocial personality disorder*. [pdf] National Institute for Health and Care. Available at:
<<http://www.nice.org.uk/nicemedia/live/11765/43046/43046.pdf>> [Accessed 4 May 2014].

National Service Framework for Mental Health, 1999. *Modern standards and service models*. [pdf] National Service Framework for Mental Health. Available at:
<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf> [Accessed 9 August 2014].

Nordoff, P. and Robbins, C., 1992. *Therapy in music for handicapped children*. London: Gollancz.

Norton, K., 1996. Management of difficult personality disorder patients. *Advances in Psychiatric* 265

- Treatment*, 2, pp.202–9.
- Nuechterlein, K.H. and Dawson, M.E. 1984. A heuristic vulnerability/stress model of schizophrenic episodes. *Schizophrenia Bulletin*, 10(2), pp.300–3.
- Odell-Miller, H., 2001. Music therapy and its relationship to psychoanalysis. In: Y. Searle and I. Streng, eds. 2001. *Where analysis meets the arts*. London: Karnac Books.
- Odell-Miller, H., 2011. Value of music therapy for people with personality disorders. *Journal of Mental Health Practice*, 14(10).
- Odell-Miller, H., 2013. Inside and outside the walls: music therapy supervision in a forensic setting. In: S.J. Compton Dickinson, H. Odell-Miller and J. Adlam, eds. 2013. *Forensic music therapy: a treatment for men and women in secure hospital settings*. London: Jessica Kingsley Publishers. Ch.2.
- Odell-Miller, H., 2014. The development of clinical music therapy in adult mental health practice: music, health and therapy. In: V. Bates, A. Bleakley and S. Goodman, eds. 2014. *Medicine, health and the arts: approaches to the medical humanities*. London: Routledge. pp.264–80.
- Odell-Miller, H., Hughes, P. and Westacott, M., 2006. An investigation into the effectiveness of the arts therapies for adults with continuing mental health problems. *Psychotherapy Research*, 16(1), pp.122–39.
- Odell-Miller, H., 2014. Music therapy for personality disorders: ‘thinking and feeling’. In: J. Edwards *The Oxford Textbook of Music Therapy*, Oxford. OUP (In press due November 2014)
- Odell-Miller, H. (2014) 'The development of clinical music therapy in adult mental health practice: music, health and therapy'. In V. Bates, A. Bleakley, and S. Goodman (eds.) *Medicine, health and the arts: approaches to the medical humanities*. London: Routledge (Published Jan 2014)
- O’Grady, L., 2011. The therapeutic potentials of creating and performing music with women in prison: a qualitative case study. In: S. Gardstrom, ed. 2011. *Qualitative Inquiries in Music Therapy*, Volume 6. Gilsum, NH: Barcelona Publishers. pp.122–52.
- O’Grady, L., Rolvsjord, R. and McFerran, K., 2014. Women performing music in prison: an exploration of the resources that come into play. *Nordic Journal of Music Therapy*, [online] Available at: <<http://www.tandfonline.com/doi/full/9.1080/08098131.2013.877518#.U-jz51Z7Btc>> [Accessed 31 March 2014].
- Parkinson, J., 2002. *Black Caribbean men in high secure psychiatric care: a descriptive-interpretative analysis*. PhD. Anglia Polytechnic University. Available at: <<http://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.248823#sthash.lqsplbMw.dpuf>> [Accessed 30 June 2014].

- Patterson, P., Birchwood, M. and Cochrane, R., 2000. Preventing the entrenchment of high expressed emotion in first episode psychosis: early developmental attachment pathways. *Australian and New Zealand Journal of Psychiatry*, 34, pp.191–97.
- Pavlicevic, M., Trevarthen, C. and Duncan, J., 2000. Improvisational music therapy and the rehabilitation of persons suffering with chronic schizophrenia. In: J.Z. Robarts, ed. 2001. *Music therapy research: growing perspectives in theory and practice*. London: British Society of Music Therapy Publications. pp.44–54.
- Payne, B.K., 2012. The music therapist're so vain the music therapist probably think this keynote is about the music therapist: expanding art and music in criminal justice. *American Journal of Criminal Justice*, 37(3), pp.291–305.
- Pedersen, I.N., 1999. Music therapy as holding and re-organizing work with schizophrenic and psychotic patients. In: T. Wigram. and J. De Backer 2004. *Improvisation: methods and techniques for music therapy clinicians, educators and students*. London: Jessica Kingsley Publishers. Ch.2.
- Pedersen, I.N., 2014. Music therapy in psychiatry today – do we need specialization based on the reduction of diagnosis-specific symptoms or on the overall development of patients' resources? Or do we need both? *Nordic Journal of Music Therapy*, 23(2), pp.173–94.
- Pollock, P., 2001. *Cognitive analytic therapy for adult survivors of childhood abuse: approaches to treatment and case management*. Chichester: Wiley-Blackwell.
- Pollock, P. and Belshaw, T., 1998. Cognitive analytic therapy for offenders. *The Journal of Forensic Psychiatry*, 9(3), pp.629-642.
- Pollock, P.H., Broadbent, M., Clarke, S., Dorrian, A.J. and Ryle, A., 2001. Assessment. The Personality Structure Questionnaire (PSQ): a measure of the multiple self states model of identity disturbance in cognitive analytic therapy. *Clinical Psychology and Psychotherapy*, 6, pp.59–72.
- Pollock, P.H. and Stowell-Smith, M., 2006. Cognitive analytic therapy applied to offending: theory, tools and practice. In: P.H. Pollock, M. Stowell-Smith and M. Gopfert. 2006. *Cognitive analytic therapy for offenders: a new approach to forensic psychotherapy*. London and New York: Routledge. Ch.1.
- Pollock, P.H., Stowell-Smith, M. and Gopfert, M., 2006. *Cognitive analytic therapy for offenders: a new approach to forensic psychotherapy*. London and New York: Routledge.
- Pool, J. and Odell-Miller, H., 2011. Aggression in music therapy and its role in creativity with reference to personality disorder. *The Arts in Psychotherapy*, 38(3), pp.169–77.
- Potter, S., 2004. Untying the knots: relational states of mind in cognitive analytic therapy. *Reformulation*, 21, pp.14–22.

- Priestley, M., 1994. *Analytical music therapy*. Phoenixville, PA: Barcelona Publishers.
- Putnam, F.W. and Bernstein-Carlson, E. The Dissociative Experiences Scale (DES). *European Psychiatry*, 20(2), pp.145–51.
- Quinsey, V.L., Harris, T.G., Rice, E.M., Cormier, C.A., 1998. *Violent offenders: appraising and managing risk*. 2nd ed. Washington DC: American Psychological Association.
- Radosevich, D.M. 2005. *Designing an outcomes research study*. [pdf] Available at: http://www.jblearning.com/samples/0763734411/chapter_02.pdf [Accessed 6 September 2014].
- Reddy, V. and Trevarthen, C., 2004. What we learn about babies from engaging with their emotions. *Zero to Three*, 24(3), pp.9–15.
- Richards, E., Davies, A. and Barwick, N., 2014. *Group music therapy: a group analytic approach*. London: Routledge.
- Rio, R.E. and Tenney, K.S., 2002. Music therapy for juvenile offenders in residential treatment. *Music Therapy Perspectives*, 20(2), pp.89–97.
- Riordan, D.C., 2008. Being ordinary in extraordinary places: reflective practice of the total situation in a total institution. *Psychoanalytic Psychotherapy*, 22(3), pp.196–217.
- Risby, E. and Van Sant, S., 2001. Ethnicity and mood disorders. In: Bhugra, D. and Bhui, K., eds. 2001. *Cross-cultural psychiatry: a practical guide*. London: Arnold. Ch.20.
- Ritchie, J.D. and Lingham, R., 1994. *The report of the inquiry into the care and treatment of Christopher Clunis*. London: HMSO.
- Robarts, J., 1996. Music therapy with autistic children. In: C. Trevarthen, K. Aitken, D. Papoudi and J. Robarts, eds. 1996. *Children with autism: diagnosis and interventions to meet their needs*. London: Jessica Kingsley Publishers.
- Roberts, R., 2013. Music, mourning and the matrix: death and loss within a forensic music therapy group. In: S.J. Compton Dickinson, H. Odell-Miller and J. Adlam, eds. 2013. *Forensic music therapy: a treatment for men and women in secure hospital settings*. London: Jessica Kingsley Publishers. pp.137–53.
- Rogers, P., 2000. Truth or illusion: evidence- based practice in the real world. In: J.Z. Robarts, ed. 2000. *Music Therapy Research. Growing perspectives in theory and practice*. London: British Society for Music Therapy. Vol.1, pp.11-33.
- Romanowski, B., 2007. Benefits and limitations of music therapy with psychiatric patients in the penitentiary system. *Music Therapy Today*, 8 (3), pp.462–75.
- Rosenburg, M., 1979. *Conceiving the self*. New York: Basic Books.
- Ross, J., Quayle, E., Newman, E. and Tansey, L., 2013. The impact of psychological therapies on violent behaviour in clinical and forensic settings: a systematic review. *Aggression and Violent Behaviour*, 18(6), pp.761–73.

- Roth, A. and Fonagy, P., with Parry, G., Target, M., Woods, R., 2005. *What works for whom? A critical review of psychotherapy research*. New York: Guilford Press.
- Ryle, A., 1975. Self-to-self, self-to-other: the world's shortest account of object relations theory. *New Psychiatry*, April, pp.12–13.
- Ryle, A., 1979. The focus in brief interpretative psychotherapy: dilemmas, traps and snags as target problems. *British Journal of Psychiatry*, 134, pp.46–54.
- Ryle, A., 1980. Some measures of goal attainment in focussed integrative active psychotherapy: 15 cases. *British Journal of Psychiatry*, 137, pp.475–86.
- Ryle, A., 1991. Object relations theory and activity theory: a proposed link by way of the procedural sequence model. *British Journal of Medical Psychology*, 64(4), pp.307–16.
- Ryle, A., 1995a. *Cognitive analytic therapy developments in theory and practice*. Chichester: John Wiley and Sons.
- Ryle, A., 1995b. Transference and counter-transference variations in the course of the cognitive-analytic therapy of two borderline patients: the relation to the diagrammatic reformulation of self-states. *British Journal of Medical Psychology*, 68, pp.109–24.
- Ryle, A., 1996. Ogden's autistic-contiguous position and the role of interpretation in psychoanalytic theory building. *British Journal of Medical Psychology*, 69, pp.129–38.
- Ryle, A., 1997a. *The multiple self-states model* in: Cognitive analytic therapy and borderline personality disorder. In: Chichester: John Wiley and Sons. Ch.3.
- Ryle, A., 1997b. The structure and development of borderline personality disorder: a proposed model. *British Journal of Psychiatry*, 170, pp.82–87.
- Ryle, A., 2000. A CAT-derived one to three session intervention for repeated deliberate self-harm: a description of the model and initial experience of trainee psychiatrists in using it. *British Journal of Medical Psychology*, 73, pp.179–96.
- Ryle, A., 2007b. Investigating the phenomenology of borderline personality disorder with the states description procedure: clinical implications. *Clinical Psychology and Psychotherapy*, 14, pp.329–41.
- Ryle, A., 2007a. States characterization procedure (SCP) for supporting the reformulation of patients with borderline/dissociative features (October 2007). *Reformulation: Theory and Practice in CAT*, 29, pp.9–11.
- Ryle, A. and Beard, H., 1993. The integrative effect of reformulation: Cognitive analytic therapy with a patient with borderline personality disorder. *British Journal of Medical Psychology*, 66, pp.249–58.
- Ryle, A. and Golynkina, K., 2000. Effectiveness of time-limited cognitive analytic therapy of borderline personality disorder: factors associated with outcome.

- British Journal of Medical Psychology*, 73, pp.197–29.
- Ryle, A. and Kellett, S., 2005. *Cognitive analytic therapy (CAT) for borderline personality disorder (BPD): an audit of current practice and a study of the process of change*. Unpublished document, apply to ACAT (online) at www.acat.me.
- Ryle, A. and Kerr, I., 2002. *Introducing cognitive analytic therapy*. Chichester: John Wiley and Sons.
- Sacks, O., 1976. *Awakenings*. Harmondsworth: Pelican Books.
- Santos, K., 2001. *Unlocking the power – creative music therapy with mentally disordered offenders*. Unpublished document, Broadmoor Hospital.
- Sarkar, S.P., 2005. The ‘other 23 hours’: special problems of psychotherapy in a ‘special’ hospital. *Psychoanalytic Psychotherapy*, 19(1), pp.4–16.
- Scanlon, C., 2012. The traumatised-organisation-in-the-mind: opening up space for difficult conversations in difficult places. In: J. Adlam, A. Aiyebuisi, P. Kleinot, A. Motz and C. Scanlon, eds. 2012. *The therapeutic milieu under fire: security and insecurity in forensic mental health*. Forensic Focus 34. London. Jessica Kingsley Publishers. pp.212–28.
- Scanlon, C. and Adlam, J., 2012. Dangerous liaisons: close encounters of the unboundaried kind. In: A. Aiyegbusi and G. Kelly, eds. 2012. *Professional and therapeutic boundaries in forensic mental health practice*. London: Jessica Kingsley Publishers pp.240–51.
- Schacht, T.E. and Henry, W.P., 1994. Modeling recurrent patterns of interpersonal relationship with structural equation analysis of social behaviour: The **SASB-CMP**. *Psychotherapy Research*, 4(3–4), pp.208–21.
- Schore, A., 2003. *Affect dysregulation and disorders of the self*. New York: W.W. Norton and Company.
- Schneider, K., 1959. *Clinical Psychopathology*. New York: Grune and Stratton.
- Scully, A.T., 1979. *Museums of madness: the social organisation of insanity in 19th century England*. New York: St Martins Press.
- Sedgwick, P., 2013. What is a patient preference trial? *British Medical Journal*, 347, p.5970.
- Seiser, L. and Wastell, C. 2002 *Interventions and techniques*. Buckingham and Philadelphia, PA: Open University Press
- Shepherd, G., Boardman, J. and Slade, M., 2008. *Making recovery a reality*. London: Sainsbury Centre for Mental Health.
- Silber, L., 2005. Bars behind bars: the impact of a women’s prison choir on social harmony. *Music Education Research*, 7(2), pp.251–71.
- Siris, S.G., 2000. Depression in schizophrenia: perspective in the era of ‘atypical’ antipsychotic agents. *American Journal of Psychiatry*, 157, pp.1379–89.
- Available at: <<http://journals.psychiatryonline.org/article.aspx?articleid=174309>>

[Accessed 5 September 2014].

- Slade, M., 2002. Routine outcome assessment in mental health services. *Psychological Medicine*, 32(8), pp.1229–343
- Slade, M. and Priebe, S., 2001. Are randomised controlled trials the only gold that glitters? *British Journal of Psychiatry*, 179, pp.286–87.
- Sleight, V. and Compton Dickinson, S.J., 2013. Risks, ruptures and the role of the co-therapist. In: S.J. Compton Dickinson, H. Odell-Miller and J. Adlam, eds. 2013. *Forensic music therapy: a treatment for men and women in secure hospital settings*. London: Jessica Kingsley Publishers. Ch.9.
- Sloboda, A., 1997 Music therapy and psychotic violence. In: E.V. Welldon and C. Van Velsen, eds. 1997. *A practical guide to forensic psychotherapy*. London: Jessica Kingsley Publishers. pp.121–29.
- Sloboda, J., 1985. *The musical mind: the cognitive psychology of music*. Oxford: Clarendon Press.
- Smeijsters, H. and Cleven, G., 2006. The treatment of aggression using arts therapies in forensic psychiatry: results of a qualitative inquiry. *The Arts in Psychotherapy*, 33(1), pp.37–58.
- Smith, J.A., Flowers, P. and Larkin, M., 2009. *Interpretative phenomenological analysis: theory, method and research*. London and Los Angeles: Sage.
- Stenudd, S., 2007. *Psychoanalysis of myth – the Jungian archetypes*. [online] Available at: <<http://www.stenudd.com/myth/freudjung/jung-archetypes.htm>> [Accessed 28 June 2014].
- Stern, D.N., 1985. *The interpersonal world of the infant: a view from psychoanalysis and development*. New York: Basic Books.
- Stevens, A., 2006. The archetypes. In: R. Papadopoulos, ed. *The handbook of Jungian psychology*. Hove, East Sussex: Routledge. Ch.3.
- Stiles, W.B., Leach, C., Barkham, M., Lucock, S., Shapiro, D.A., Iveson, M. and Hardy, G.E., 2003. Early sudden gains in psychotherapy under routine clinic conditions: practice-based evidence. *Journal of Consulting and Clinical Psychology*, 71, pp.14–21.
- Stiles, W.B., Leiman, M. Shapiro, D.A., Hardy, G.E., Barkham, M., Detert, N.B. and Llewelyn, S.P., 2005. What does the first exchange tell? Dialogical sequence analysis and assimilation in very brief therapy. *Psychotherapy Research*, 16, pp.408–21.
- Stirman, S.W., De Rubeis, R.J., Crits-Christoph, P. and Rothman, A., 2005. Can the randomised controlled literature generalize to non-randomised patients? *Journal of Consulting and Clinical Psychology*, 73(1), pp.127–35.

- Stravinsky, I. and Craft, R., 1962. *Expositions and developments*. Reprint 1981. Los Angeles and Berkeley: University of California Press.
- Strehlow, G., 2014 submitted for publication: Music therapy interaction patterns in relation to BPD patients. In: *Nordic Journal of Music Therapy*
- Talwar, N., Crawford, M., Maratos, A., Nur, U., McDermott, O. and Procter, S., 2006. Music therapy for in-patients with schizophrenia: exploratory randomised controlled trial. *British Journal of Psychiatry*, 189, pp.405–9.
- Tansella, M. and Thornicroft, G., 1998. A conceptual framework for mental health services: the matrix model. [Psychological Medicine](#), 28(3), pp.503–8.
- Tapp, J., Warren, F., Fife-Schaw, C., Perkins, D. and Moore, E., 2013. What do the experts by experience tell us about ‘what works’ in high secure forensic inpatient hospital services? *Journal of Forensic Psychiatry and Psychology*, 24(2), pp.160–78.
- Thomas, S.D.M., 2005. *Inverse Care? Comparing needs and satisfaction with services between prisoners and patients in contact with forensic mental health services*. PhD. Institute of Psychiatry, King’s College London.
- Thornicroft, G., Tansella, M., Becker, T. and Knapp, M., 2004. The personal impact of schizophrenia in Europe. *Schizophrenia Research*. 69(2–3), pp.125–32.
- Tinnin, L., 1990. Mental unity, altered states of consciousness and dissociation. *Dissociation*, 3(3), pp.154–59.
- Torgerson, D., Sibbald, B., 1998. Understanding controlled trials: what is a patient preference trial? *British Medical Journal*, 316(7128), pp.360-360.
- Tracey, T.J. and Kokotovic, A.M., 2001. Factor structure of the working alliance inventory: psychological assessment. *Journal of Consulting and Clinical Psychology*, 1(3), pp.207–9.
- Trevarthen, C., 2003. Intimate contact from birth: how we know one another by touch, voice and expression of movement. In: K. White, ed. 2004. *Touch: attachment and the body*. London: Karnac Books. pp.1–15.
- Trevarthen, C., 2007. Moving experiences: perceiving as action with a sense of purpose. In: G.J. Pepping and M.A. Greal, eds. 2007. *Closing the gap: the scientific writings of David N. Lee*. London and New Jersey: Erlbaum.
- Trevarthen, C., Delafield-Butt, J. and Schögler, B., 2011. The psychobiology of human gesture: form, rhythm, and melody in infants’ movements of narration. In: A. Gritten and E. King, eds. 2011. *New perspectives on music and gesture*. Aldershot: Ashgate.
- Tuastad, L. and O’Grady, L., 2013. Music therapy inside and outside prison – a freedom practice? *Nordic Journal of Music Therapy*, 22(3), pp.210–32.
- Tucek, G. and Fachner, J., 2014. *14th World Congress of Music Therapy: Collection of Abstracts*. Available at:

- <http://www.musictherapy2014.org/fileadmin/download/Abstract_Book_WCMT_2014_01.pdf> [Accessed 15 November 2014].
- Tyrer, P., Nur, U., Crawford, M., Karlsen, S., McLean, C., Rao, B. and Johnson, T., 2005. The social functioning questionnaire: a rapid and robust measure of perceived functioning. *International Journal of Social Psychiatry*, 51(3), pp.265–75.
- Unkefer, R.F., 1990. *Music therapy in the treatment of adults with mental disorders: theoretical bases and clinical interventions*. New York and Toronto: Schirmer Books.
- Van de Wall, W., 1924. *The utilization of music in prisons and mental hospitals, its application in the treatment and care of the morally and mentally afflicted*. New York: National Bureau for the Advancement of Music.
- Vygotsky, L.S., 1978. *The mind in society*. Cambridge, MA: Harvard University Press.
- Watson, T., Bragg, A. and Jeffcote, N., 2003. Working together: integrated multi-disciplinary practice with women. In: N. Jeffcote and T. Watson, eds. 2003. *Working with women in secure treatment settings*. Forensic Focus 27. London: Jessica Kingsley Publishers. pp.91–108.
- Welldon, E., 1988. *Mother, madonna, whore: the idealization and denigration of motherhood*. London: Free Association Books.
- Welldon, E., 2002. *Ideas in psychoanalysis: sadomasochism*. Cambridge: Icon Books.
- Welldon, E., Woods, J. and Williams, A., 1997. *Forensic group psychotherapy: the portman clinic approach*. London: Karnac Books.
- Wertz, F.J., 1985. Methods and findings in an empirical analysis of ‘being criminally victimized’. In: A. Giorgi, ed. 1985. *Phenomenology and psychological research*. Pittsburgh, PA: Duquesne University Press. pp.144–216.
- Wheeler, B.L., 1995. *Music therapy research: quantitative and qualitative perspectives*. Phoenixville, PA: Barcelona Publishers.
- Wigram, T., 2004. *Improvisation: methods and techniques for music therapy clinicians, educators and students*. London: Jessica Kingsley Publishers.
- Wigram, T. and De Backer, J., 1999. *Clinical applications of music therapy in psychiatry*. London: Jessica Kingsley Publishers.
- Wigram, A., 2002. *A comprehensive guide to music therapy*. London: JKP Publishers.
- Wilde McCormick, E., 1996. The psychotherapy file: an aid to understanding ourselves better. In: E. Wilde McCormick. 2002. *Change for the better*. London: Sage Publications. pp.310–18. Appendix 1.
- Wilde McCormick, E., 2002. *Change for the better*. London: Sage Publications.

- Williams, J.B.W., 1988. A structured interview guide for the Hamilton depression rating scale. *Archives of General Psychiatry*, 45(8), pp.742–47.
- Yakeley, J. and Adshead, G., 2013. Locks, keys, and security of mind: psychodynamic approaches to forensic psychiatry. *Journal of American Academic Psychiatry and Law*, 41(1), pp.46–48.
- Zar, J.H., 1998. *Biostatistical analysis*. 4th ed. Upper Saddle River, NJ: Prentice Hall. p.147.
- The Zito Trust, 1994. The Zito Trust. [online] Information about the Zito Trust is available at: <http://www.netdoctor.co.uk/brain-and-nervous-system/support_groups/006278.htm> [Accessed 28 July 2014].

ANGLIA RUSKIN UNIVERSITY

A FEASIBILITY TRIAL OF
GROUP COGNITIVE ANALYTIC MUSIC THERAPY
IN SECURE HOSPITAL SETTINGS

Volume 2: APPENDICES

STELLA COMPTON DICKINSON

A thesis in partial fulfilment of the
requirements of Anglia Ruskin University
for the degree of Doctor of Philosophy

Submitted: November 2014

Contents

Contents	ii
List of tables	v
List of figures	vi
Appendix 1: Pilot 1 and 2.....	1
Appendix 1a: Pilot 1: Demographic table and results PROQ2	1
Appendix 1b: Pilot 2: Demographic table and results PROQ2	2
Appendix 2: Recruitment and Consent.....	3
Appendix 2a: Recruitment flyer: patients.....	3
Appendix 2b: Recruitment flyer: research assistants	5
Appendix 2c: Letter to responsible clinicians	7
Appendix 2d: Letter to named nurses	11
Appendix 2e: Patient and Staff informed consent.....	12
Appendix 3: Instruments	14
Appendix 3a: Primary measure PROQ2	14
Appendix 3b: Circle	21
Appendix 3c: MDI.....	23
Description	24
Sample of publications using or describing the MDI	24
Multiscale Dissociation Inventory® scoring	26
Appendix 3d: BES	30
Appendix 3e: BES permission to use.....	32
Appendix 3f: Client Satisfaction Questionnaire (CSQ-8).....	33
Appendix 3g: Arts Therapies – PSQ.....	34
Appendix 4: Intensity of Standard Care and distribution of data	36
Appendix 4a: Standard care.....	36
Appendix 4b: Distribution of data (checking for normality)	37
Appendix 4c: Treatment effect across time and by groups.....	49
Appendix 4d: Distribution of data, secondary measures MDI, BES, CIRCLE (checking for normality)	52
<i>4d1: Disengagement</i>	<i>52</i>
<i>4d2: Emotional Constriction.....</i>	<i>54</i>
<i>4d3: Cognitive empathy</i>	<i>56</i>
<i>4d4: Affective Empathy domain.....</i>	<i>58</i>

4d5: TOTAL score.....	60
4d6: Hostile	62
4d7: Withdrawn	64
4d8: Friendly.....	66
4d9: Sociable	68
Appendix 4e: Treatment effect across time and by groups (secondary measures) Hypothesis 1 ...	70
4e1: MDI domain disengagement at time points 1, 2 and 3 by groups.....	70
4e2: CIRCLE domains at time points 1, 2 and 3 by Groups.....	70
Appendix 4f: Treatment effect across time and by groups (secondary measures) Hypothesis 2	73
4f1: BES domains at time points 1, 2 and 3 by Groups	73
4f2: MDI domains at time points 1, 2 and 3 respectively by Groups	74
Appendix 5: Feedback	75
Appendix 5a: MT Patient Satisfaction Questionnaire	75
Appendix 5b: Client Satisfaction Questionnaire:	76
Appendix 5c: IPA Arts Therapies Questionnaire	78
Appendix 6: Raw interview transcripts.....	81
Appendix 6a: First semi-structured interview with Victoria Sleight	81
Appendix 6b: First semi-structured interview with Claire Newman after the G-Cant Group	90
Appendix 6c: Semi Structured interview with Claire for the end of treatment stage (session 16). ..	102
Appendix 6d: Semi Structured interview with Victoria for the end of treatment stage (session 16)	112
7.1.The evidence- based Manual for Group Cognitive Analytic Music Therapy.....	122
7.1.1 Information for Stakeholders	122
7.1.2. Summary of the treatment programme:	123
7.1.3. Selection Criteria:	124
7.2. The Four Stages of Treatment:	124
7.2.1. Initial Consultation/Screening follows referral.....	125
7.2.2. Initial Individual Assessment.....	125
7.2.3. Treatment Stage 1 Sessions 1-6: Mindfulness. Being present.	125
Recognition task.....	125
Purpose of sessions:	126
7.2.4.Treatment Stage 2 Sessions 7-12: Emotional Regulation	126
Process Tools.....	126
7.2.5. Treatment Stage 3 Sessions 13-18: Interpersonal Effectiveness.....	127
7.2.6. Treatment Stage 4: Sessions 19-24 Distress tolerance	127

7.3.1. <i>Music Therapy Outcome measures</i>	129
7.4 Guidance for Patients	129
7.4.1. <i>Mindfulness</i> :.....	129
7.4.2. <i>Emotional Recognition and Regulation: Guidance for Patients</i>	131
7.4.3. Interpersonal effectiveness and Conflict Resolution: Guidance for Patients	133
7.4.4. <i>Distress Tolerance: Guidance for Patients</i>	133

List of tables

NB. Only tables created from data obtained by the study are listed, and not tables from pre-existing documents.

Table A1a.i: Demographic and clinical characteristics of sample from Pilot 1	1
Table A1a.ii: Results of the PROQ2 subscale scores for Pilot 1 sample	1
Table A1b.i: Demographic and clinical characteristics of sample from Pilot 2 (N=4)	2
Table A1b.ii: Results of the PROQ2 subscale scores for Pilot 2 sample	2
Table A4a.i: Intensity in hours	36
Table A4a.ii: Intensity – Comparison between groups	36

List of figures

NB. Only figures created from data obtained by the study are listed, and not figures from pre-existing documents.

Distribution of data

Figure A4b.i: UD1	37
Figure A4b.ii: UD2	37
Figure A4b.iii: UD3	38
Figure A4b.iv: UD4	38
Figure A4b.v: NC1.....	39
Figure A4b.vi: NC2.....	39
Figure A4b.vii: NC3.....	40
Figure A4b.viii: NC4.....	40
Figure A4b.ix: UN1	41
Figure A4b.x: UN2	41
Figure A4b.xi: UN3	42
Figure A4b.xii: UN4	42
Figure A4b.xiii: UC1	43
Figure A4b.xiv: UC2	43
Figure A4b.xv: UC3	44
Figure A4b.xvi: UC4	44
Figure A4b.xvii: LD1.....	45
Figure A4b.xviii: LD2.....	45
Figure A4b.xix: LD3.....	46
Figure A4b.xx: LD4	46
Figure A4b.xxi: ND1.....	47
Figure A4b.xxii: ND2.....	47
Figure A4b.xxiii: ND3.....	48
Figure A4b.xxiv: ND4.....	48
Figure A4c.i: Upper Neutral (UN) treatment and control across time.....	49
Figure A4c.ii: Upper Close (UC) treatment and control across time.....	49
Figure A4c.iii: Neutral Close (NC) treatment and control across time.....	50
Figure A4c.iv: Lower Distant (LD) treatment and control across time.	50
Figure A4c.v: Neutral Distant (ND) treatment and control across time.	51

Figure A4c.vi: Upper Distant (UD) treatment and control across time.	51
Figure A4d1.i: DENG1.....	52
Figure A4d1.ii: DENG2.....	52
Figure A4d1.iii: DENG3.....	53
Figure A4d1.iv: DENG4.....	53
Figure A4d2.i: ECON1.....	54
Figure A4d2.ii: ECON2.....	54
Figure A4d2.iii: ECON3.....	55
Figure A4d2.iv: ECON4.....	55
Figure A4d3.i: cog_emp1.....	56
Figure A4d3.ii: cog_emp2.....	56
Figure A4d3.iii: cog_emp3.....	57
Figure A4d3.iv: cog_emp4.....	57
Figure A4d4.i: affec_emp1.....	58
Figure A4d4.ii: affec_emp2.....	58
Figure A4d4.iii: affec_emp3.....	59
Figure A4d4.iv: affec_emp4.....	59
Figure A4d5.i: BES_total1.....	60
Figure A4d5.ii: BES_total2.....	60
Figure A4d5.iii: BES_total3.....	61
Figure A4d5.iv: BES_total4.....	61
Figure A4d6.i: hostile1.....	62
Figure A4d6.ii: hostile2.....	62
Figure A4d6.iii: hostile3.....	63
Figure A4d6.iv: hostile4.....	63
Figure A4d7.i: withdrawn1.....	64
Figure A4d7.ii: withdrawn2.....	64
Figure A4d7.iii: withdrawn3.....	65
Figure A4d7.iv: withdrawn4.....	65
Figure A4d8.i: friendly1.....	66
Figure A4d8.ii: friendly2.....	66
Figure A4d8.iii: friendly3.....	67
Figure A4d8.iv: friendly4.....	67
Figure A4d9.i: sociable1.....	68

Figure A4d9.i: sociable2	68
Figure A4d9.iii: sociable3	69
Figure A4d9.iv: sociable4	69
Figure A4e1: Domain disengagement – treatment and control across time.	70
Figure A4e2.i: Domain hostile – treatment and control across time.	70
Figure A4e2.ii: Domain sociable -- treatment and control across time.....	71
Figure A4e2.iii: Domain friendly -- treatment and control across time.....	71
Figure A4e2.iv: Domain withdrawn -- treatment and control across time.....	72
Figure A4f1.i: Cognitive empathy -- treatment and control across time.....	73
Figure A4f1.ii: Cognitive empathy -- treatment and control across time.	73
Figure A4f1.iii: total score – cognitive and affective empathy -- treatment and control across time..	74
Figure a4f2.i: Emotional constriction, - treatment and control across time	74

Appendix 1: Pilot 1 and 2

Appendix 1a: Pilot 1: Demographic table and results PROQ2

Table A1a.i: Demographic and clinical characteristics of sample from Pilot 1

	<i>N=4</i>
Gender	5 (100%)
▪ Male	
Age (mean)	mean 40.6 (SD10.31)
Ethnicity	
▪ White UK	X3
▪ Black British	X2
▪ Asian	X0
Primary Diagnoses:	
▪ Personality disorder	X1
▪ Severe and enduring mental illness & PD traits:	X4

Table A1a.ii: Results of the PROQ2 subscale scores for Pilot 1 sample

	Time 1 Start of Treatment		Time 2 Finish of Treatment	
	Mean	SD	Mean	SD
NC	15.66	(12.58)	8.0	(6.55)
LC	7.33	(6.80)	6.66	(8.32)
LN	13.66	(8.14)	11.66	(5.03)
LD	14.0	(12.16)	11.0	(7.0)

Notes

For the NC score, the mean difference between Time1 and Time 2 was 7.66

For the LC score, the mean difference between Time 1 and Time 2 was 0.67

For the LN score, the mean difference between Time 1 and Time 2 was 2.00

For the LD score, the mean difference between Time 1 and Time 2 was 3.00

Appendix 1b: Pilot 2: Demographic table and results PROQ2

Table A1b.i: Demographic and clinical characteristics of sample from Pilot 2 (N=4)

Gender <ul style="list-style-type: none"> Female 	4 (100%)
Age (mean)	mean 39.5 (SD5.19)
Ethnicity <ul style="list-style-type: none"> White UK Black British Asian 	X3 X1 X0
Primary Diagnoses: <ul style="list-style-type: none"> Personality disorder Severe and enduring mental illness: 	X3 X1

Table A1b.ii: Results of the PROQ2 subscale scores for Pilot 2 sample

	Time 1 Baseline. Control period		Time 2 Treatment start		Time 3 Treatment finish	
	Mean	SD	Mean	SD	Mean	SD
NC	25 *	(4.40)	27.75	(0.5)	23.50	(5.80)
LC	22.25	(3.30)	24.00	(3.46)	19.75	(8.09)
LN	22.00	(7.34)	23.00	(10.70)	19.75	(13.17)
LD	21.75	(7.88)	22.00	(9.48)	19.75	(11.14)

Notes

For the NC score, the mean difference between Time1 and Time 2 (Control period) was –2.75 and between Time 2 and Time 3 Treatment period was 4.25

For the LC score, the mean difference between Time 1 and Time 2 was –1.75 and between Time 2 and Time 3 was 4.25

For the LN score, the mean difference between Time 1 and Time 2 was –1 .0 and between Time 2 and Time 3 was 3.25

For the LD score, the mean difference between Time 1 and Time 2 was –0 .25 and between Time 2 and Time 3 was 2.25

Appendix 2: Recruitment and Consent

Appendix 2a: Recruitment flyer: patients



Are you interested in doing something different?

Would you like to try something that could help you and others move on?

Yes?

Then read on!



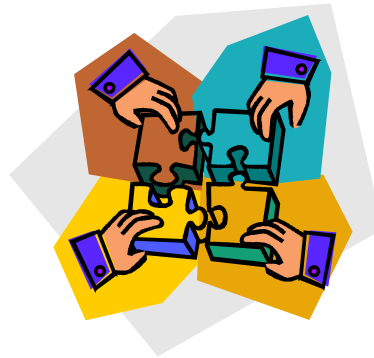
There is a Music Therapy Project happening in the hospital that needs people like you to help with getting things right.

A new treatment has been developed that is enjoyable, feels good and importantly can help people to move on

We need volunteers to take part in a small group to help say what does and doesn't work.

If you would like to have your voice heard and be part of an exciting new project then please volunteer now!

If you have any questions then please ask your named nurse
to contact: The Arts Therapies Team on: 7929
or speak to Stella next Thursday when she will be visiting the wards.



Do you want to develop your research experience and
be credited in a research publication?

An exciting research opportunity has arisen at [REDACTED]
Hospital.

We are seeking to recruit a Research Assistant from permanent staff
to work closely on a time-limited project with the chief investigator
Stella Compton, Clinical Research Lead in Arts Therapies.

A controlled feasibility Mixed methods study into the clinical effectiveness of
forensic music therapy.(g-camt)

This secondment will enhance your continuous professional
development and portfolio. It is open to staff members from the
Therapies and Education department, Nursing or Psychology Staff.

Please phone Karen Elliott, Manager Arts Therapies on extension
7875, or email stella.compton-dickinson@nottshc.nhs.uk for full
details. You will then need to discuss this with your line manager.

Here at [REDACTED] over eight years we have established music therapy as an MDT intervention. Stella
Compton has developed a research study and treatment manual through the health service and
population research department. We plan to start implementation of the trial in the mental health
directorate in February.

Your role will require you to help twenty male patients from the mental health directorate to fill in four Outcome Measures at the start, mid point, end and follow-up of a sixteen session course of group cognitive analytic music therapy.

That will involve four weeks of work.

One week at each of these points.

(Approx 37 hours x 4)

Your role will also involve gaining their informed consent. (In this way the music therapists delivering the treatment and the chief investigator will be masked to the level of engagement of each patient). So your role is very important in ensuring a rigorously scientific study is completed. Stella will collaborate with and advise you.

You will be joining the Research Team.

Members are:

Stella Compton: Chief Investigator,

Victoria Sleight , Claire Newman: Music Therapist Research Assistant,

Dr Chris Beeley: Senior Evaluation Manager.

Karen Elliott: Manager Arts Therapies,

Sharron Oddy> Forensic Psychologist (Patient Satisfaction Evaluation)

Supervisors:

Research Supervisors\:

Professor Paul McCrone, Professor Helen Odell-Miller

Chief Forensic Advisor: Dr Gill McGauley

Appendix 2c: Letter to responsible clinicians

xxxxx

Healthcare NHS Trust 

positive
about forensic services

Positive about mental health and learning disability

2-May-11

Dear(RC,)

I am writing to inform you that ethical approval has now been granted to implement a small 'mixed methods controlled feasibility trial' within the Mental Health and National Learning Disability Directorate at [REDACTED]. The trial is supported by the Therapies and Education Department and Dr Mike Harris: Executive Director. I enclose details of the research team and the inclusion and exclusion criteria for your information.

The aim of this research is to develop a forensic music therapy treatment manual and to test the clinical effectiveness of Group Cognitive Analytic Music Therapy (g-camt). A model that has been developed and piloted at Arnold Lodge and [REDACTED] over the last eight years.

Patient Letters and an information sheet have been ethically approved and these are ready to be sent. To ensure that the study group reflects the population of the directorate I will need to send out eighty letters to patients in order to recruit a total of twenty patients for the treatment intervention study group n=10 and the control group n=10.

Prior to that implementation, I am therefore writing to ask you if there are any patients that you **do not** want us to approach.

I would value your interest and support as we move into the recruitment stage for this psychological therapies treatment intervention trial. Here is some further information:

Assisted by Dr Chris Beeley (Senior Evaluation Manager), I will match the demographic data of the study and control groups. I can provide you with a full copy of the approved research protocol on request.

Some patients may not want to have g-camt music therapy intervention, but if they are well matched to the criteria, they might be interested to participate in the control group. All patients who participate will be assisted by research assistant Stella Nugent to fill in three self-report outcome

measures, (This process takes about one hour.) at four time points over the sixteen weeks treatment programme.

Dr Chris Beeley will be take observational measurements of risk from IRIs and it is hoped that nurses will contribute by filling in the Chart of Interpersonal Reactions in Closed Living Environments (CIRCLE). (Blackburn & Glasgow 2006) with the participating patients.

(This measure can be completed in about five minutes)

I can be contacted during the day by email stella.comptondickinson@gmail.com or by phone on 07966 528298, . I will next be on-site at [REDACTED] on May 12th . I am available to meet with you after midday. I would be pleased to hear from your secretary or yourself to make arrangements. Thank you for your time and attention.

Best regards,

Stella Compton.

Research Lead Arts Therapies: Forensic Services

Honorary Researcher. Health Service and Population Research. Institute of Pyschiatry.

A controlled, feasibility study of mixed methods design into the clinical effectiveness of Group Cognitive Analytic Music Therapy (g-camt) for men who have offended and who are receiving secure hospital treatment.

Chief Investigator Stella Compton

Research Team

Victoria Sleight Music Therapist

Claire Newman Music Therapist

Dr Chris Beeley Senior Evaluation Manager

Karen Elliott, Manager, Arts and Slt Therapies

Research Assistants:

1. Stella Nugent; Assistant Psychologist

2.Sharron Oddy Forensic Psychologist. Wathwood

(Patient satisfaction questionnaires)

Research Supervisors

Professor Helen Odell-Miller Anglia Ruskin University

Professor Paul McCrone, Health service and Population Research Institute of Psychiatry

Research Advisor

Dr Gill Mc Gauley Consultant and Reader in Forensic Psychotherapy, St Georges University of London.

On-site

Dr Andy Benn Consultant Clinical and Chartered Forensic Psychologist

Mental Health & National Learning Disability Directorate

Dr John Milton. Michael Ferriter. Research Leads, Forensic Services.

Recruitment of sample:

Sample Characteristics:

- Men who have committed offences
- Detained under the Mental Health Act 2008 for high risk behaviours
- Age 18-65 Years
- Resident in this high secure treatment setting in the mental health services

Inclusion Criteria

Men aged between 18 and 65 years old

Who have a primary diagnosis of mental illness

Who have an IQ of over 70, with the capacity to give informed consent

Who have resided at XXXXX hospital for over eighteen months

Who have sufficient verbal comprehension, and with support to complete the outcome measures

Whose acuteness of psychotic illness does not preclude the completion of the outcome measures.

Who may have an interest to work therapeutically with the non-verbal medium of music

Ethnic Origin: patients will be recruited across all ethnic groups

Exclusion Criteria

Men who have a diagnosis of organic brain disease

Men who have physical disability which impairs movement to a degree which precludes active participation in the group process

Men with serious physical illness

Men with an IQ lower than 70

Men who are already attending music or art therapy

Men who have insufficient verbal comprehension due to English not being their first language if we are not able to secure/fund translators(every effort will made to do so).

Men with limited literacy or intellectual skills who are unable to complete the tools and service user evaluation despite help from the research assistant

Women who are resident at this hospital in gender specific services

Appendix 2d: Letter to named nurses

xxxxx

Healthcare
NHS Trust 

positive
about forensic services

Positive about mental health and learning disability

Arts Therapies Department

Date:

Dear

We're writing to you because you have said that you are interested to take part in the Music Therapy research study.

We have provided you with the information pack and understand that you have had plenty of time to make your decision.

We are therefore enclosing the consent form for you to complete with you named nurse or another member of the team. Please ask a member of staff to contact us on extension: 7929 if you require further help.

One copy will be kept in your file and your nurse should return the other copy to me at the Arts Therapies Department.

The research team would like to take this opportunity to thank you personally and to welcome you to the project.

Yours sincerely,

Stella Compton

Clinical Research Lead: Arts Therapies

Appendix 2e: Patient and Staff informed consent

CONSENT FORM

Version 1 for Patients

Title of Study: A controlled, feasibility study of mixed methods design into the clinical effectiveness of Group Cognitive Analytic Music Therapy (g-camt) for male offender patients who are receiving secure hospital treatment.

REC ref:

Name of Researcher: Stella Compton Dickinson

Name of Participant:
box

Please initial

1. I confirm that I have read and understand the information sheet version number 1. Datedfor the above study, and I have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that there are three levels of choice and I have circled my choice below: ☐
 - a) I choose to participate in the treatment group, but if I am not available at the time of the first treatment start time, I may have to wait for the treatment. I understand that I will receive the treatment if I want to have it.
 - b) I choose to participate by being in the control group and that I will have the treatment after the first ten patients have received it.
 - c) I choose to participate by being in the control group but I do not want the treatment when it becomes available.
4. I understand that relevant sections of data collected in the study may be looked at by the music therapists, with the Chief Investigator in the study: ☐

Stella Compton and her Academic research Supervisors. That Stella Compton, who is the Research Lead in Arts Therapies in XXXXX Healthcare NHS Trust and the Senior Evaluation Manager in this Trust, Dr Chris Beeley will analyse the data. I give permission for these individuals to collect, store, analyse and publish information obtained from my participation in this study. I understand that all my personal details will be kept confidential.

5. I understand that interviews to complete the questionnaires will not be recorded verbally, also that I will have an opportunity to give my verbal and written feedback about what it was like to participate in the study. Furthermore that direct quotes from the patient satisfaction interviews will be made anonymous and may be used in the study report, also that these may be used in subsequent publications. ☐
6. I understand that sessions may be recorded as standard music therapy procedure, for group and therapist reflection, that these recordings may be considered in clinical supervision, but they will not be used for any other research purposes. ☐
7. I agree to participate in the above study.
8. I would / would not like to receive a summary of results from this study (Please delete as appropriate)

Name of Participant	Date	Signature

Name of Person taking consent	Date	Signature
(if different from Principal Investigator)		

2 copies: 1 for participant, 1 for the project notes

Appendix 3: Instruments

Appendix 3a: Primary measure PROQ2

PROQ2 : THE PERSON'S RELATING TO OTHERS QUESTIONNAIRE

PLEASE READ THIS BEFORE YOU START

The statements listed here are the sorts of feelings and attitudes which people sometimes have about or towards other people. Please read each statement carefully and indicate, by ticking the appropriate column, the extent to which you think it applies to you.

Try to be completely frank and honest about yourself. Avoid answering the way you would like to be or the way you would like others to think of you, rather than the way you really are.

Try, as far as possible, to place your ticks in the "Nearly always true" and the "Rarely true" columns. The two middle columns are really for if you cannot make up your mind.

Please make sure that you have not missed out a page and that you have put a tick against every statement.

nearly
always

quite
often

some-
times

rarely
true

1. I keep myself to myself				
2. I feel that nobody seems to care about me				
3. I easily give in to people				
4. I consider my needs are worth fighting for				
5. I hold on to people too much				
6. I have no difficulty telling another person what to do				
7. I derive pleasure from looking after others				
8. It is easy for other people to change my mind				
9. I cannot tolerate disobedience				
10. I can never convince myself that people really love me				
11. I am willing to accept instruction from others				
12. Even the slightest criticism can affect me for hours				
13. I am easily intimidated by others				
14. I am prepared to put up a fight to get what I want				
15. I like being held and made a fuss of				
16. I usually get on with whatever I am required to do				

nearly
always

quite
often

some-
times

rarely
true

17. I think I am a very warm person				
18. I find it hard to stand up to people				
19. I like to be the one in control				
20. I prefer other people to take the lead				
21. I have a tendency to cling to people				
22. I let people push me around a lot				
23. I tend to keep my feelings to myself				
24. I can be very protective towards someone who is less able than myself				
25. I have a dread of being rejected				
26. I can be quite ruthless when I need to be				
27. I am more a follower than a leader				
28. I cannot resist trying to help those in need				
29. When people I like go away I long for their return				
30. It annoys me when people will not do what I expect of them				
31. I have no difficulty doing what people tell me				
32. I tend to get back at people who offend me				

nearly
always quite
often some-
times rarely
true

33. I cannot bear to be left on my own				
34. I don't like to argue with people in case they end up disliking me				
35. I need a lot of close contact with others				
36. I prefer it when someone else is in control				
37. Caring for others is something which comes naturally to me				
38. I enjoy spending time on my own				
39. I appreciate it when others tell me what to do				
40. I have to come out on top				
41. I get too involved with people I like				
42. I am easily put down by other people				
43. I do not let people get away with insulting me				
44. People know they can always turn to me for help				
45. I respect those in authority				
46. I don't like to be the one who gives in				
47. I easily tire of other people's company				
48. I seem to need a lot of looking after				

**nearly
always** **quite
often** **some-
times** **rarely
true**

49. When I tell people what to do I expect them to do it				
50. I can never be sure that people approve of me				
51. I leave it to others to make the decisions				
52. I find it easy to be affectionate				
53. I don't like others to know too much about me				
54. I get annoyed if people stand in my way				
55. I don't trust people very easily				
56. When there's a confrontation I back off				
57. I want to reach out to people in trouble				
58. I don't take too much notice of other people				
59. I am inclined to put people in their place				
60. I feel uncomfortable if things are not done the way I want them				
61. I can be very caring when I need to be				
62. I tend to look to others for guidance				
63. I find it best to keep out of other people's way				
64. I can't help fussing over someone I feel close to				

**nearly
always** **quite
often** **some-
times** **rarely
true**

65. Looking up to someone is something which comes easily to me				
66. I know that there are people I can turn to if I need to				
67. I find it hard to tolerate people standing between me and what I want				
68. If I can't do something I find someone who can show me				
69. I try to arrange things so that people do what I want				
70. I can't just stand by when I realize that someone needs help				
71. When there's an argument I tend to give in				
72. I am afraid that people are going to lose interest in me				
73. I am willing to go along with whatever other people say				
74. I can't say "No" when it comes to helping other people				
75. I don't like to be too involved with people				
76. I am prepared to stand up for my rights				
77. I feel drawn to people who are worse off than myself				
78. I don't feel I've very much to offer other people				
79. I tend to get so close to people I can't bear to let go of them				
80. When things go wrong I'm inclined to think it's my fault				

**nearly
always** **quite
often** **some-
times** **rarely
true**

81. I tend to bully people				
82. I feel lost when there is no-one to turn to for advice				
83. If you get too close to people they always let you down				
84. If I have to, I can take control of a situation				
85. I tend to put other people's needs before my own				
86. I try not to let others get the upper hand				
87. I do not retaliate when others insult me				
88. I find it pleasant to get away from people				
89. Rather than risk criticism I say nothing				
90. Getting my own way is very important to me				
91. I can be very critical of other people				
92. I prefer to keep people at a safe distance				
93. When people disagree with me I argue with them				
94. I do not let people get too close to me				
95. I find it helpful when I can cry on someone else's shoulder				
96. I let other people organize my life for me				

Appendix 3b: Circle

CIRCLE (Revised October 1993) **(Chart of Interpersonal Reactions in Closed Living Environments)**

Administration

- 1) Raters should preferably be familiar with the ratee, or should have had the opportunity to observe the ratee's behaviour regularly in out of work situations for at least one month.
- 2) Raters should familiarise themselves with the rating scale, and then observe the ratee for at least one week.

Scoring

- 1) Items are scored 0 (Not at all) to 3 (Usually), except those marked 'R' (Reversed), which are scored 3 to 0

- 2) Key

Dominant	22	26	35	36					
Coercive	9	15	18	20	37	39	42	44	
Hostile	6	12(R)	16	21	25	28(R)	31	32	49
Withdrawn	4	5(R)	8	13(R)	17(R)	45(R)			
Submissive	19	23	30(R)						
Compliant	2(R)	3	33(R)	43(R)	48(R)				
Friendly	7	14	24	27(R)	29	40	47		
Sociable	1	10	11	34	38	41			

- 3) For reliable results, obtain ratings from two independent raters.
- 4) Scores on each scale are the sum of two ratings across the relevant items.

Normative Data

N = 210 Mentally disordered offenders in a maximum security hospital

	<u>Mean</u>	<u>SD</u>
Dominant	5.81	4.84
Coercive	15.17	8.89
Hostile	13.12	7.86
Withdrawn	17.82	7.13
Submissive	7.12	3.22
Compliant	21.86	5.06
Friendly	20.69	6.91
Sociable	14.34	5.93

(These are the summed scores of two raters)

NURSE'S OBSERVATION SCALE

Patient's Name _____ No _____ Age _____

Medication _____

Ward _____ Rater _____ Date _____

INSTRUCTIONS

- 1 The following items refer to patient behaviour observed on the ward.
- 2 Ratings should be completed by staff who have had the opportunity to observe the patient regularly during the past month.
- 3 For each item, indicate whether the patient being rated shows that behaviour 'not at all', 'occasionally', etc., by putting a tick in the appropriate box.

	Not at all	Occasionally	Fairly often	Usually/ frequently
1. Joins in group activities				
2. Abuses or swears at nurses				
3. Accepts the rules				
4. Inactive unless directed to do something				
5. Attends social functions				
6. Starts fights				
7. Does ward duties as well as he is able				
8. Sits alone or keeps to himself				
9. Voices strong opinions				
10. Comes to the staff for advice or approval				
11. Makes jokes and cheerful comments				
12. Does what is necessary without supervision				
13. Starts conversations				
14. Respectful to people in authority				
15. Lies easily				
16. Threatens others with physical violence				
17. Mixes with many others				
18. Demands attention to his own rights or needs				
19. Timid or cautious with people he doesn't know				
20. Acts impulsively, on the spur of the moment				
21. Shirks obligations or responsibilities				

Appendix 3c: MDI

MULTISCALE DISSOCIATION INVENTORY (MDI)[©]

John Briere, Ph.D.

Psychological Trauma Program
Department of Psychiatry and the Behavioral Sciences
Keck School of Medicine
University of Southern California

www.johnbriere.com
jbriere@usc.edu

Citation:

Briere, J. (2002). *Multiscale Dissociation Inventory Professional Manual*.
Odessa, Florida: Psychological Assessment Resources.

Note to users: Copyright for the MDI has reverted from Psychological Assessment Resources (PAR) to John Briere, Ph.D., as of 9/2010. As a result, this test is no longer available from PAR. However, it is currently offered to researchers and clinicians at no cost from the author, as long as appropriate citation is provided in research documents. Items of the MDI can be imported into research questionnaires without further permission. The original items booklets, answer sheets, etc., are no longer available in PAR format.

This packet contains

- A description of the MDI, with representative publications
- an MDI scoring sheet
- the MDI measure,
- an MDI profile form, and
- a paper on the structure and validity of the MDI (!"#\$\$%&'(%&)*+,\$"-%&.)(%&/&012+3%&4(& 567789(&&:-&;#--<=#*+<2&*&>1?+&;#>\$2-#<2*?&=<2-+"1=+@&A*+*&B"<>&+,\$&41?+&#-=?\$& A#--<=#*+<2&:2C\$2+<"D(&&!"#\$%&'(")(*\$&#+&,-./,\$0112(34%&66EF6GE9(

&

Description

The MDI is a 30-item self-report test of dissociative symptomatology. It is fully standardized and normed, and measures six different type of dissociative response. The scales of the MDI, with their associated *alpha* reliabilities in the general population (Briere, 2002), are:

- Disengagement (*alpha* = .83)
- Depersonalization (*alpha* = .90)
- Derealization (*alpha* = .91)
- Emotional Constriction/Numbing (*alpha* = .94)
- Memory Disturbance (*alpha* = .74)
- Identity Dissociation (*alpha* = .75)
- Total Dissociation Score (*alpha* = .96)

The MDI is normed and standardized on 444 trauma-exposed individuals from the general population, and validated in clinical, community, and university samples. Scores normative and validation samples. Data on over 1,300 clinical and nonclinical individuals indicates on this measure can be converted to T-scores that allow for empirically-based clinical interpretation of clients' actual level of dissociative disturbance.

The MDI has been found to have good psychometric qualities in both the that the MDI items form five relatively independent factors or dimensions (Briere, Weathers, & Runtz, 2005). A raw Identity Dissociation scale score of 15 or higher identified 93% of those with diagnosis of Dissociative Identity Disorder (DID) and 92% of those with no diagnosis of DID in a combined clinical/community sample (Briere, 2002). Each MDI symptom item is rated according to its frequency of occurrence over the prior month, using a scale ranging from 1 (never) to 5 (very often).

The MDI requires approximately 10-15 minutes to complete for all but the most clinically impaired individuals and usually can be scored and profiled in less than 5 minutes.

Sample of publications using or describing the MDI

Briere, J., Scott, C., & Weathers, F.W. (2005). Peritraumatic and persistent dissociation in the presumed etiology of PTSD. *American Journal of Psychiatry*, 162, 2295-2301. [Download is available at: <http://www.johnbriere.com/AJP%20peridiss%20paper.pdf>]

Briere, J. (2002). *Multiscale Dissociation Inventory*. Odessa, Florida: Psychological Assessment Resources.

Briere, J. (2006). Dissociative symptoms and trauma exposure: Specificity, affect dysregulation, and posttraumatic stress. *Journal of Nervous and Mental Disease*, 194, 78-82. [Download is available at: <http://www.johnbriere.com/JNMD%2006%20paper.html>]

Briere, J., Hodges, M., & Godbout, N. (in press). Traumatic stress, affect dysregulation, and dysfunctional avoidance: A structural equation model. *Journal of Traumatic Stress*.

Briere, J., Weathers, F.W., & Runtz, M. (2005). Is dissociation a multidimensional construct?

Data from the Multiscale Dissociation Inventory. *Journal of Traumatic Stress*, 18, 221-231.
[Download is available at: <http://www.johnbriere.com/JTS%20MDI%20paper.pdf>]

Dietrich, A.M. (2003). Characteristics of child maltreatment, psychological dissociation, and somatoform dissociation of Canadian inmates. *Journal of Trauma and Dissociation*, 4, 81-100.

Dietrich, A.m. (2007). Childhood maltreatment and revictimization: the role of affect dysregulation, interpersonal relatedness difficulties and posttraumatic stress disorder. *Journal of Trauma and Dissociation*, 8, 25-51.

Galovski, T.E., & Resick, P.A. (2008). Cognitive processing therapy for posttraumatic stress disorder secondary to a motor vehicle accident: a single-subject report. *Cognitive and Behavioral Practice*, 15, 287-295.

Ginzburg, K., Koopman, C., Butler, L.D., Palesh, O.G., Kraemer, H.C., Classen, C.C., & Spiegel, D. (2006). Evidence for a dissociative subtype of post-traumatic stress disorder among help-seeking childhood sexual abuse survivors. *Journal of Trauma and Dissociation*, 7, 7-27.

Harford, P.M. (2010). The integrative use of EMDR and clinical hypnosis in the treatment of adults abused as children. *Journal of EMDR Practice and Research*, 4, 60-75.

Mitchell, J.A. (2006). Symptoms of dissociation in a forensic population. *Journal of Orthomolecular Medicine*, 21, 85-94.

Putnam, F.W. (2009). Taking the measure of dissociation. *Journal of Trauma & Dissociation*, 10, 233 – 236.

Spies, R. A., & Plake, B. S. (Eds.). (2005). *The sixteenth mental measurements yearbook*. Lincoln, NE: Buros Institute of Mental Measurements.

Taft, C.T., Resick, P.A, Watkins, L.E., & Panuzio, J. (2009). An investigation of posttraumatic stress disorder and depressive symptomatology among female victims of interpersonal trauma. *Journal of Family Violence*, 24, 407-415.

Multiscale Dissociation Inventory[®] scoring

Add items to yield raw MDI scale scores. T-scores can be obtained by using the MDI profile form (attached).

Disengagement: 1 _____ + 7 _____ + 13 _____ + 19 _____ + 25 _____ = _____

Depersonalization: 2 _____ + 8 _____ + 14 _____ + 20 _____ + 26 _____ = _____

Derealization: 3 _____ + 9 _____ + 15 _____ + 21 _____ + 27 _____ = _____

Emotional Constriction: 4 _____ + 10 _____ + 16 _____ + 22 _____ + 28 _____ = _____

Memory Disturbance: 5 _____ + 11 _____ + 17 _____ + 23 _____ + 29 _____ = _____

Identity Dissociation: 6 _____ + 12 _____ + 18 _____ + 24 _____ + 30 _____ = _____!

MDI[®]
John Briere, Ph.D.

Circle the number that indicates how often each of the following things have happened *in the last month*:

	Never	Once or twice	Sometimes	Often	Very often
1. Absent-mindedness or forgetfulness	1	2	3	4	5
2. Your body feeling like it was someone else's	1	2	3	4	5
3. Things around you suddenly seeming not quite right, a little bit off	1	2	3	4	5
4. Knowing you must be upset, but not being able to feel it	1	2	3	4	5
5. People telling you that you said or did something that you don't remember saying or doing	1	2	3	4	5
6. Feeling like there was more than one person inside of you	1	2	3	4	5
7. Not paying attention because you were in your own world	1	2	3	4	5
8. Your hands or feet not feeling connected to the rest of your body	1	2	3	4	5
9. Feeling like you were in a dream	1	2	3	4	5
10. Not having any emotions or feelings at a time when you should have been upset	1	2	3	4	5
11. Suddenly realizing that hours had gone by and not knowing what you had been doing during that time	1	2	3	4	5
12. Having different people inside of you with different names	1	2	3	4	5
13. "Spacing out"	1	2	3	4	5
14. Feeling mechanical, like a robot	1	2	3	4	5
15. Things around you suddenly seeming strange	1	2	3	4	5

Circle the number that indicates how often each of the following things have happened *in the last month*:

	Never	Once or twice	Sometimes	Often	Very often
16. Not being able to feel emotions	1	2	3	4	5
17. Suddenly finding yourself somewhere and not knowing how you got there	1	2	3	4	5
18. Different people taking charge inside your mind	1	2	3	4	5
19. Driving or walking without noticing where you were going	1	2	3	4	5
20. Feeling outside of yourself	1	2	3	4	5
21. Suddenly things around you not feeling real or familiar	1	2	3	4	5
22. Feeling frozen inside, without feelings	1	2	3	4	5
23. Having blank spells	1	2	3	4	5
24. Switching back and forth between different personalities	1	2	3	4	5
25. Staring into space without thinking	1	2	3	4	5
26. Feeling like you didn't belong in your body	1	2	3	4	5
27. Your home or work suddenly seeming unfamiliar to you	1	2	3	4	5
28. Knowing you should feel mad or sad about something, but not having any feelings	1	2	3	4	5
29. Realizing that you must have done something that you don't remember doing	1	2	3	4	5
30. Feeling like two or more people were fighting or arguing inside of yourself	1	2	3	4	5

MDI™ Profile Form

John Briere, PhD

Name _____ Age _____ Sex _____ Date ____/____/____

T score	DENG	DEPR	DERL	ECON	MEMD	IDDIS	T score
≥170		19-25			25	16-25	≥170
168							168
166					24	15	166
164							164
162		18			23		162
160			25				160
158					22	14	158
156		17	24				156
154			23		21		154
152					20	13	152
150							150
148		16			19		148
146			21				146
144			20				144
142				25	18	12	142
140			22		17		140
138		15	21		16		138
136					15		136
134					14		134
132					13		132
130					12		130
128	25	14	19	24			128
126							126
124	24		18	23	17		124
122		13	17	22		11	122
120	23			21	16		120
118				20	15		118
116	22	12	16	19	14		116
114			15	18	13		114
112	21		14	17	12		112
110			13	16	11		110
108	20	11	12	15	10		108
106							106
104	19						104
102							102
100	18						100
98							98
96	17	10	11	13	10		96
94			10	12	9		94
92	16		9	11	8		92
90			8	10	7		90
88	15	9	7	9	6		88
86			6	8			86
84	14		5	7			84
82			4	6			82
80	13	8	3	5			80
78			2	4			78
76	12		1	3			76
74				2			74
72	11	7		1			72
70							70
68	10						68
66							66
64	9	6					64
62							62
60	8						60
58							58
56	7						56
54							54
52	6	5	5	5	5	5	52
50							50
48	5						48
46							46
≤44							≤44
Raw score							Raw score
T score							T score
	DENG	DEPR	DERL	ECON	MEMD	IDDIS	

Appendix 3d: BES

The following are characteristics that may or may not apply to you. Please tick one answer for each statement to indicate how much you agree or disagree with each statement. Please answer as honestly as you can.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. My friend's emotions don't affect me much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. After being with a friend who is sad about something, I usually feel sad.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I can understand my friend's happiness when she/he does well at something.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I get frightened when I watch characters in a good scary movie.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I get caught up in other people's feelings easily.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I find it hard to know when my friends are frightened.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I don't become sad when I see other people crying.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Other people's feelings don't bother me at all.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. When someone is feeling 'down' I can usually understand how they feel.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I can usually work out when my friends are scared.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
11. I often become sad when watching sad things on TV or in films.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I can often understand how people are feeling even before they tell me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Seeing a person who has been angered has no effect on my feelings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I can usually work out when people are cheerful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I tend to feel scared when I am with friends who are afraid.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I can usually realise quickly when a friend is angry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I often get swept up in my friend's feelings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. My friend's unhappiness doesn't make me feel anything	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I am not usually aware of my friend's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I have trouble figuring out when my friends are happy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 3e: BES permission to use

Basic Empathy Scale©

Dr. Darrick Jolliffe
 Institute of Criminology
 University of Cambridge
 Cambridge, United Kingdom
 CB3 9DT

* Email: dj211@cam.ac.uk *
 Phone: +44 1223 335 360

I agree:

1. The Basic Empathy Scale will be used for research purposes only unless otherwise agreed with Dr. Darrick Jolliffe.
2. The Basic Empathy Scale will be kept completely confidential. I will not distribute the Basic Empathy Scale in any way.
3. I will provide a copy of all material written by myself pertaining to the Basic Empathy Scale to Dr. Darrick Jolliffe for comment before submission.
4. I will provide a labeled electronic copy of all data collected using the Basic Empathy Scale to contribute to the future validation of the scale. If my data is ever used for validation and subsequently published I will be rightfully acknowledged.

Signed: Stella Compton Dickenson Date: 28/9/11

Print Name: STELLA COMPTON

Address: ARTS THERAPIES, T.E.D.

XXXXXXXXXXXX

HOSPITAL

XXXXXXXXXXXX

Post Code: XXXXXXXXXXXX

Email: stella.compton-dickenson@ XXXXXXXXXXXX nhs.uk

Phone: 01777 248321 ex 7929.


Copyright 2005 by Dr. Darrick Jolliffe.

pdf to email please.

Appendix 3f: Client Satisfaction Questionnaire (CSQ-8)

(Excerpt reproduced by permission of Dr Clifford Attkisson)

CSQ-8 UK English

	CLIENT SATISFACTION QUESTIONNAIRE CSQ-8
---	--

Please help us improve our service by answering some questions about the help that you have received. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Thank you very much. We appreciate your help.

CIRCLE YOUR ANSWERS

1. How would you rate the quality of service you received?

4 <i>Excellent</i>	3 <i>Good</i>	2 <i>Fair</i>	1 <i>Poor</i>
--------------------	---------------	---------------	---------------

2. Did you get the kind of service you wanted?

1 <i>No, definitely not</i>	2 <i>No, not really</i>	3 <i>Yes, generally</i>	4 <i>Yes, definitely</i>
-----------------------------	-------------------------	-------------------------	--------------------------

3. To what extent has our service met your needs?

4 <i>Almost all of my needs have been met</i>	3 <i>Most of my needs have been met</i>	2 <i>Only a few of my needs have been met</i>	1 <i>None of my needs have been met</i>
---	---	---	---

4. If a friend were in need of similar help, would you recommend our service to him or her?

1 <i>No, definitely not</i>	2 <i>No, I don't think so</i>	3 <i>Yes, I think so</i>	4 <i>Yes, definitely</i>
-----------------------------	-------------------------------	--------------------------	--------------------------

5. How satisfied are you with the amount of help you received?

1 <i>Quite dissatisfied</i>	2 <i>Indifferent or mildly dissatisfied</i>	3 <i>Mostly satisfied</i>	4 <i>Very satisfied</i>
-----------------------------	---	---------------------------	-------------------------

6. Have the services you received helped you to deal more effectively with your problems?

4 <i>Yes, they helped a great deal</i>	3 <i>Yes, they helped somewhat</i>	2 <i>No, they really didn't help</i>	1 <i>No, they seemed to make things worse</i>
--	------------------------------------	--------------------------------------	---

7. In an overall, general sense, how satisfied are you with the service you received?

4 <i>Very satisfied</i>	3 <i>Mostly satisfied</i>	2 <i>Indifferent or mildly dissatisfied</i>	1 <i>Quite dissatisfied</i>
-------------------------	---------------------------	---	-----------------------------

8. If you were to seek help again, would you come back to our service?

1 <i>No, definitely not</i>	2 <i>No, I don't think so</i>	3 <i>Yes, I think so</i>	4 <i>Yes, definitely</i>
-----------------------------	-------------------------------	--------------------------	--------------------------

Distributed by Tamalpais Matrix Systems, LLC

info@CSQscales.com

www.CSQscales.com

Copyright © 1979, 1989, 1990, 2013 Clifford Attkisson, Ph.D.

Use, transfer, copying, reproduction, merger, translation, modification, or enhancement (in any format including electronic), in whole or in part is forbidden without written permission

TMS 1805

Appendix 3g: Arts Therapies – PSQ

Music Therapy Patient Satisfaction Questionnaire

Compton,S. & Beeley,C.(2012) developed from Odell-Miller, H. Hughes,P. and Westacott (2006)

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
The therapy was enjoyable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The therapy was helpful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What was it that made the therapy helpful?

.....

The therapy was helpful because?

It helped me to relate to other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It helped me to build my self esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It helped me to cope with my issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It helped me to think about myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It helped me to express my feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How do you think that it has helped you to change?

.....

What did you find difficult within the therapy?

I felt self conscious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I did not feel ready	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt exposed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I did not understand what I was expected to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What would have helped you to get more out the therapy?

I would have found:

More instruction helpful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More sessions helpful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More time in sessions helpful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More structure helpful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More freedom in the therapy helpful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please mark along the line your rating of the overall experience:

I did not have a good
experience in therapy

I had an excellent
experience in therapy

[_____]

Adapted for forensic services by Stella Compton Dickinson from Helen Odell-Miller et al (2001). An investigation into the Effectiveness of the Arts Therapies by measuring symptomatic and significant life change for people between ages 16-65 with continuing mental health problems.

Interview Questions

Ref SC. 28.6.06. Edit 31.3.08. 2nd Edit Art Therapies Team. 7.8.08. 3rd edit Dr C Beeley & Stella Compton 4.11.09

Appendix 4: Intensity of Standard Care and distribution of data

Appendix 4a: Standard care

Table A4a.i: Intensity in hours

	Psychology	Physical Activities	Music	Other Activities	Day Care Activity
SPSS1 (T)	72	0	0	120	0
SPSS2	2	0	38	62	0
SPSS3	14	0	0	61	0
SPSS4	0	43	0	73	43
SPSS6	0	61	40	232	61
SPSS7	0	81	12	121	81
SPSS8	0	0	0	51	0
SPSS9	3	0	0	50	0
SPSS10	0	7	0	115	7
SPSS11 (C)	2	65	0	85	65
SPSS12	69	96	0	37	96
SPSS13	72	102	52	7	102
SPSS14	0	0	0	51	0
SPSS15	48	85	36	145	85
SPSS16	54	5	0	29	5

Table A4a.ii: Intensity – Comparison between groups

	Treatment Group (n=9)	Control Group (n=6)
Psychology	Mean = 10 hours SD = 23.65 Range = 0-72 hours (4 in therapy)	Mean = 41 hours SD = 32.14 Range = 0-72 hours (5 in therapy)
Physical Activities	Mean = 21 hours SD = 31.79 Range = 0-81 hours (4 doing sports)	Mean = 59 hours SD = 45.445 Range = 0-102 hours (5 doing sports)
Music	Mean = 10 hours SD = 16.91 Range = 0-40 hours (3 doing music)	Mean = 15 hours SD = 23.28 Range = 0-52 (2 doing music)
Other Activities	Mean = 98 hours SD = 58.16 Range = 50-232 hours (everyone)	Mean = 59 hours SD = 49.44 Range = 7-145 (everyone)
CDU-RM?	Mean = 34 hours SD = 27.56 Range = 0-79 hours (4 doing CDU-RM)	Mean = 29 hours SD = 22.54 Range = 0-57 (5 doing CDU-RM)

Appendix 4b: Distribution of data (checking for normality)

Proq2 domains at time points 1, 2 and 3 respectively by Groups

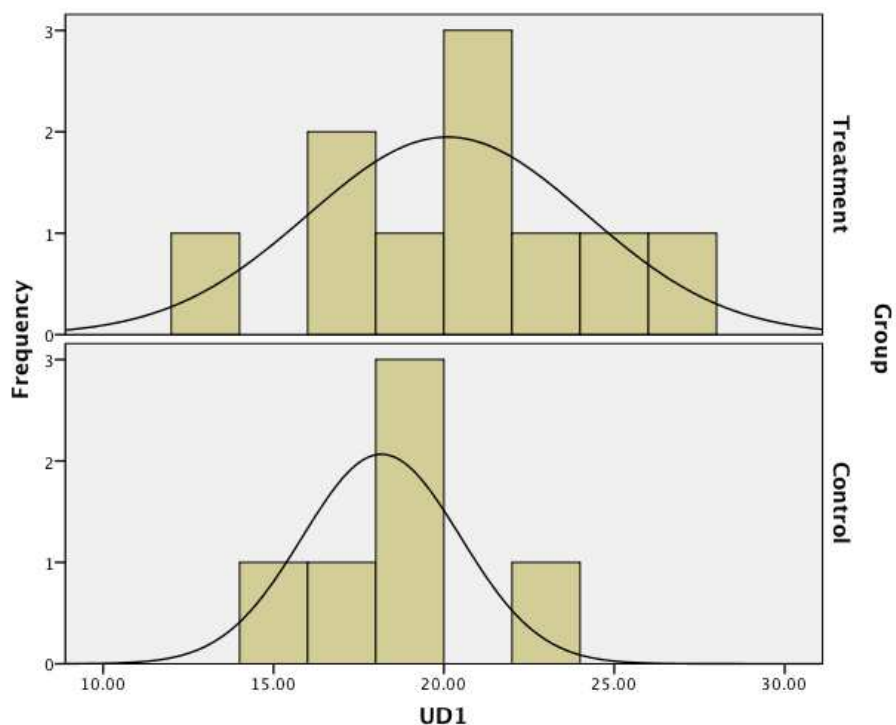


Figure A4b.i: UD1

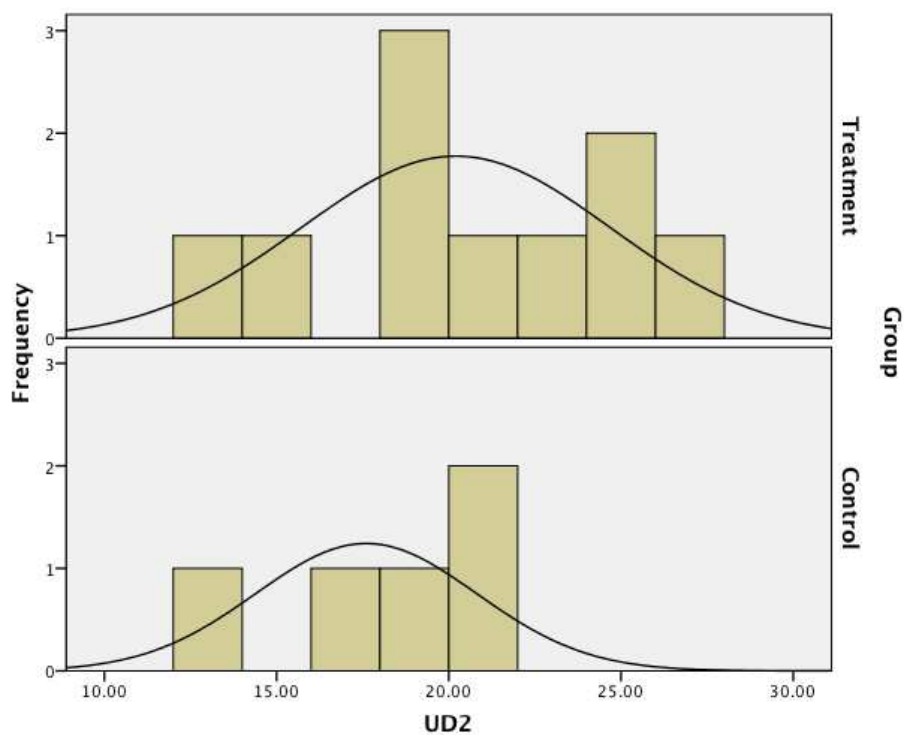


Figure A4b.ii: UD2

N.B. (For UD3 and NC2 below, the x dimension starts at lower score of 5.00)

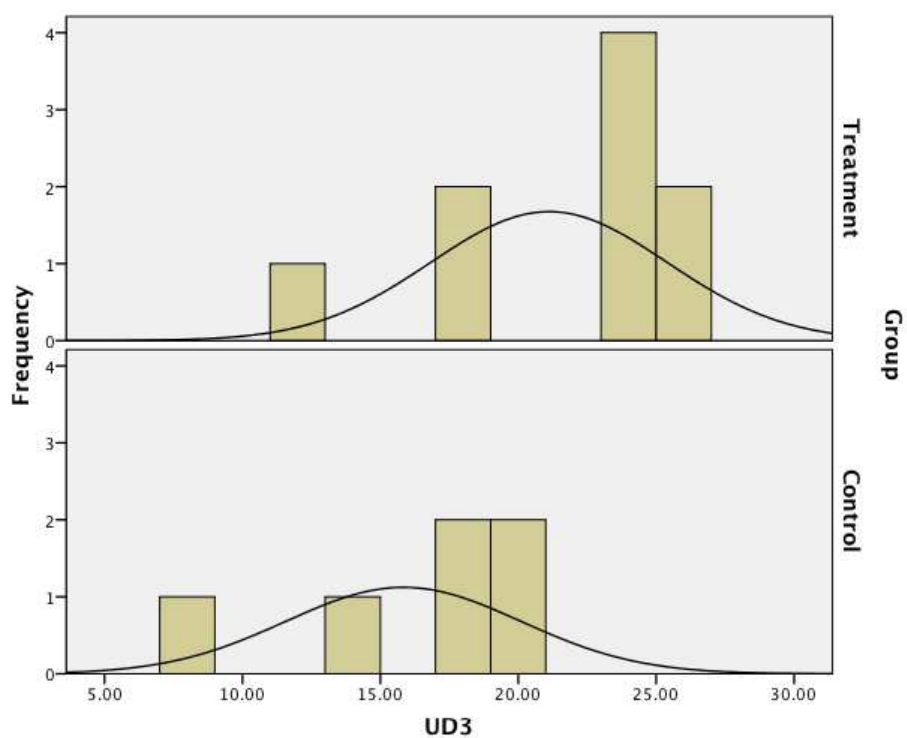


Figure A4b.iii: UD3

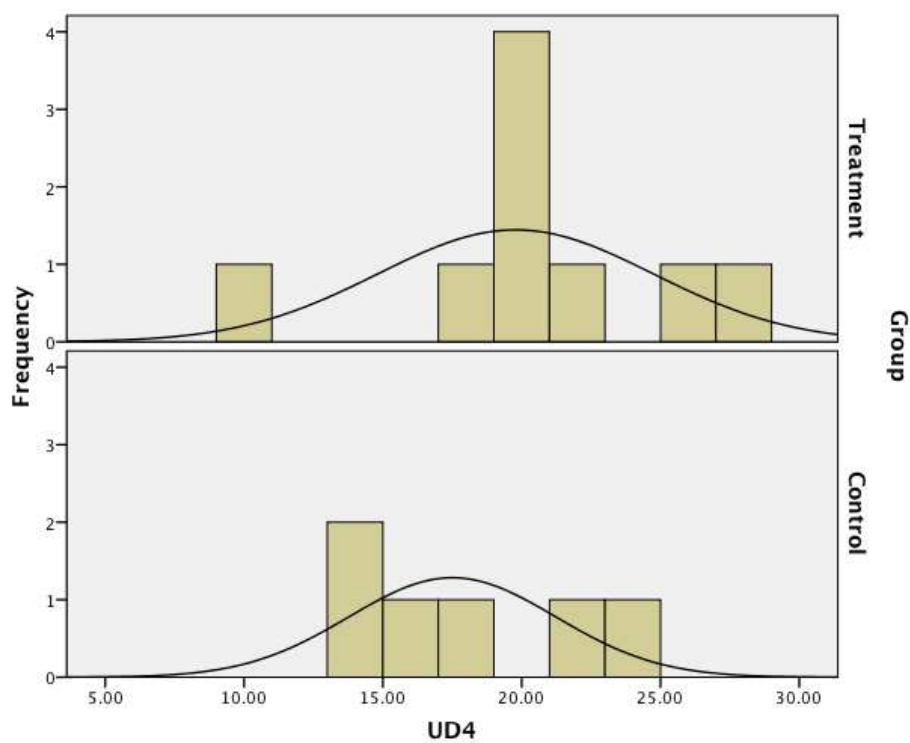


Figure A4b.iv: UD4

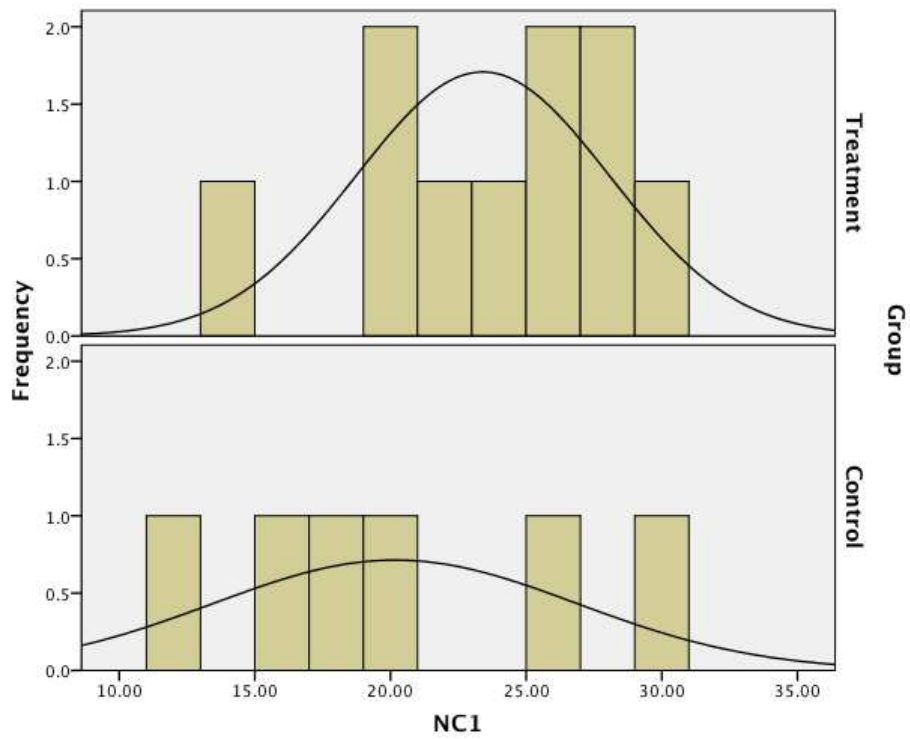


Figure A4b.v: NC1

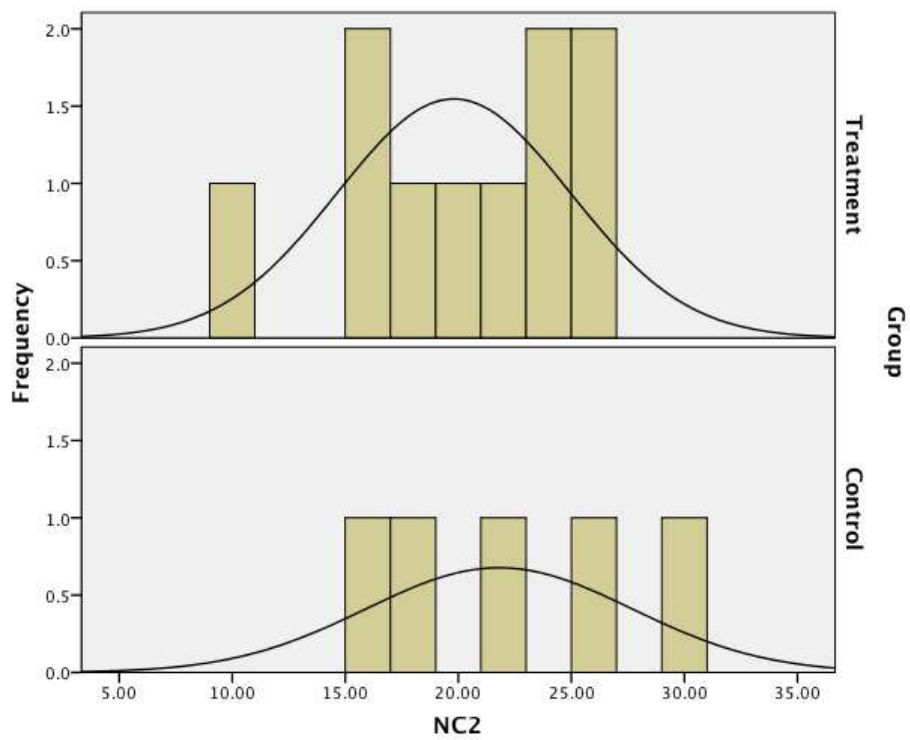


Figure A4b.vi: NC2

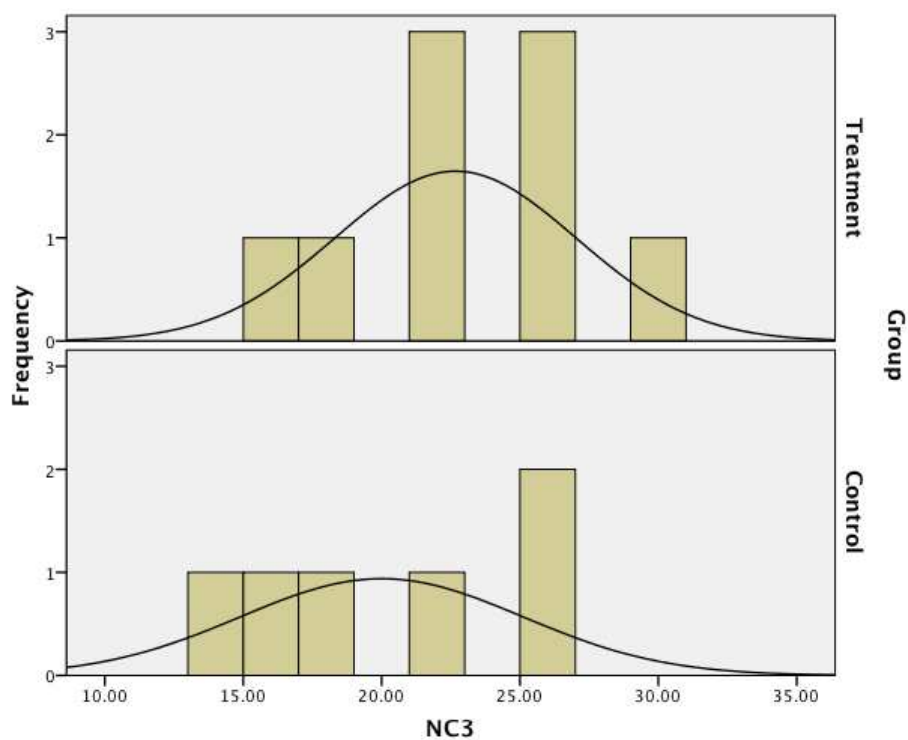


Figure A4b.vii: NC3

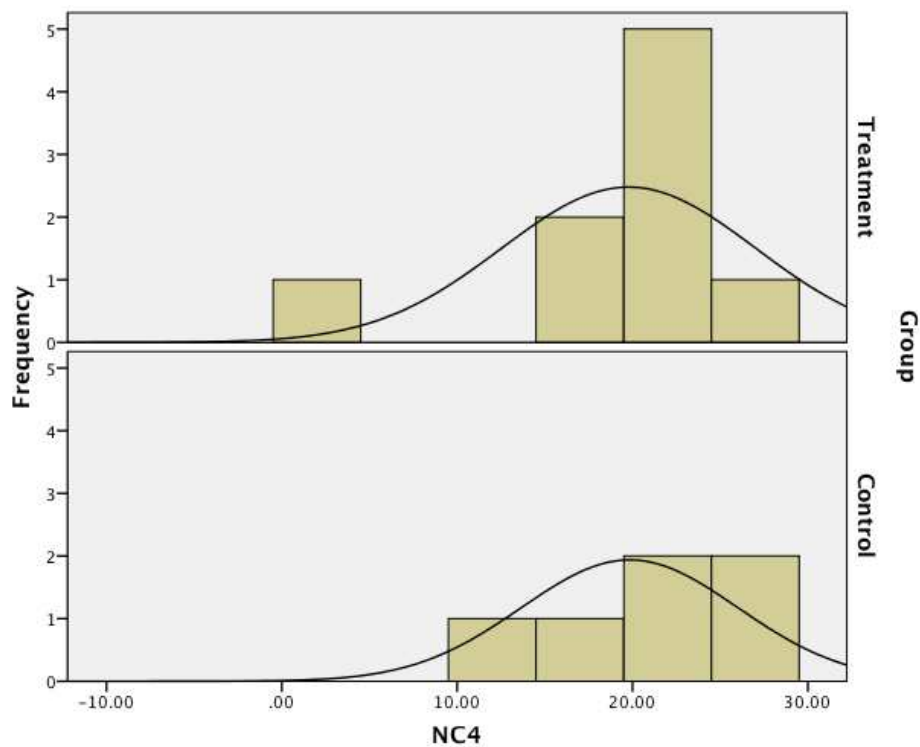


Figure A4b.viii: NC4

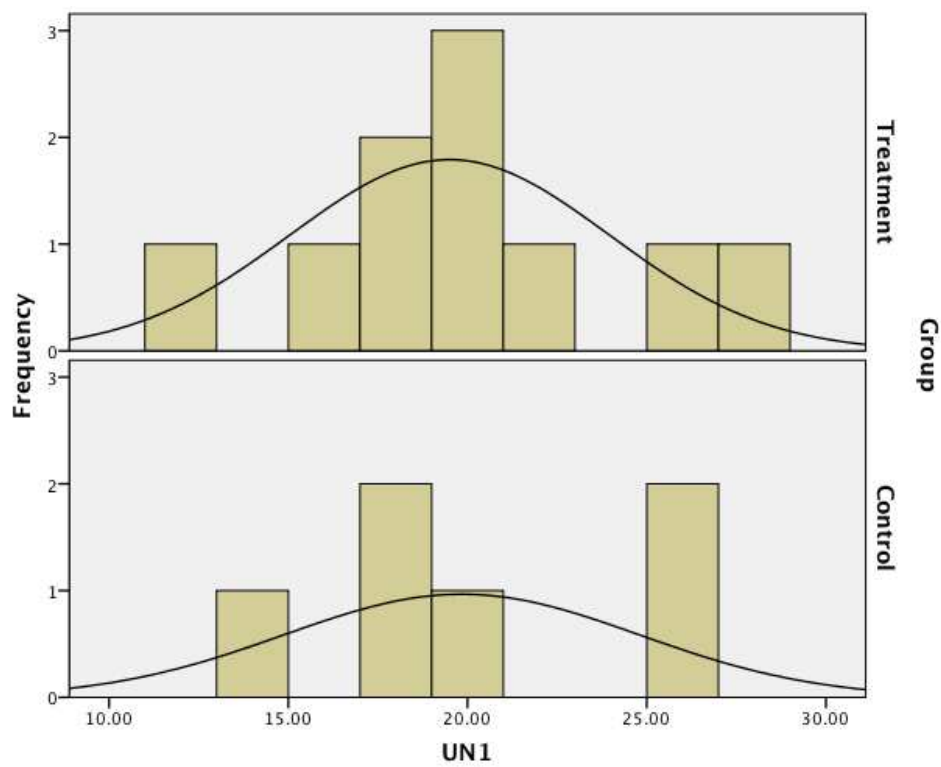


Figure A4b.ix: UN1

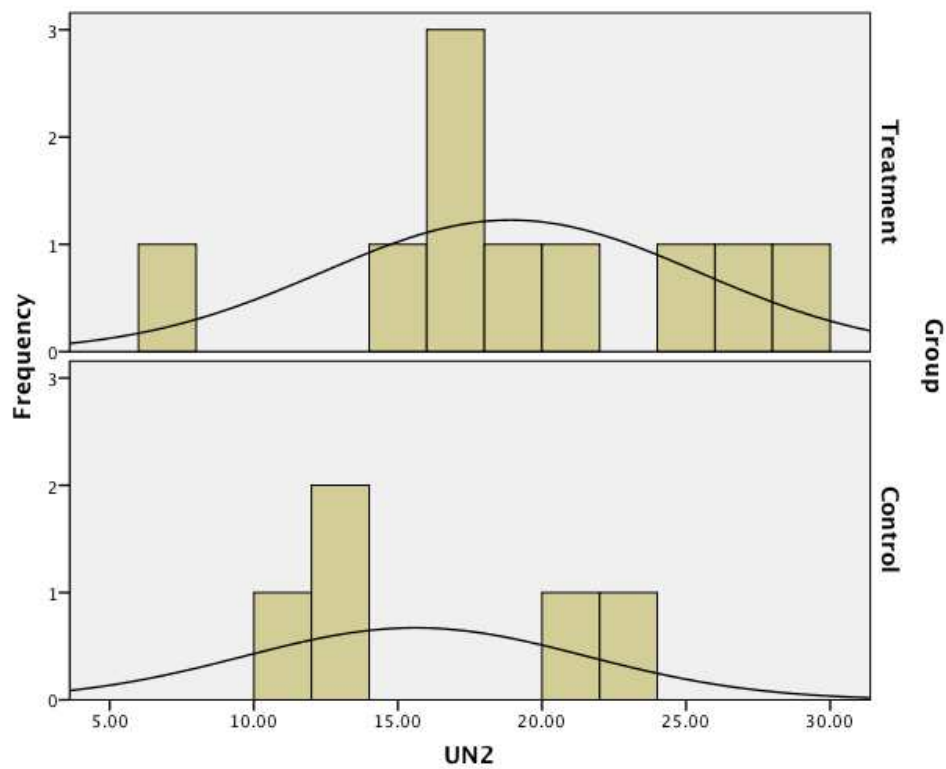


Figure A4b.x: UN2

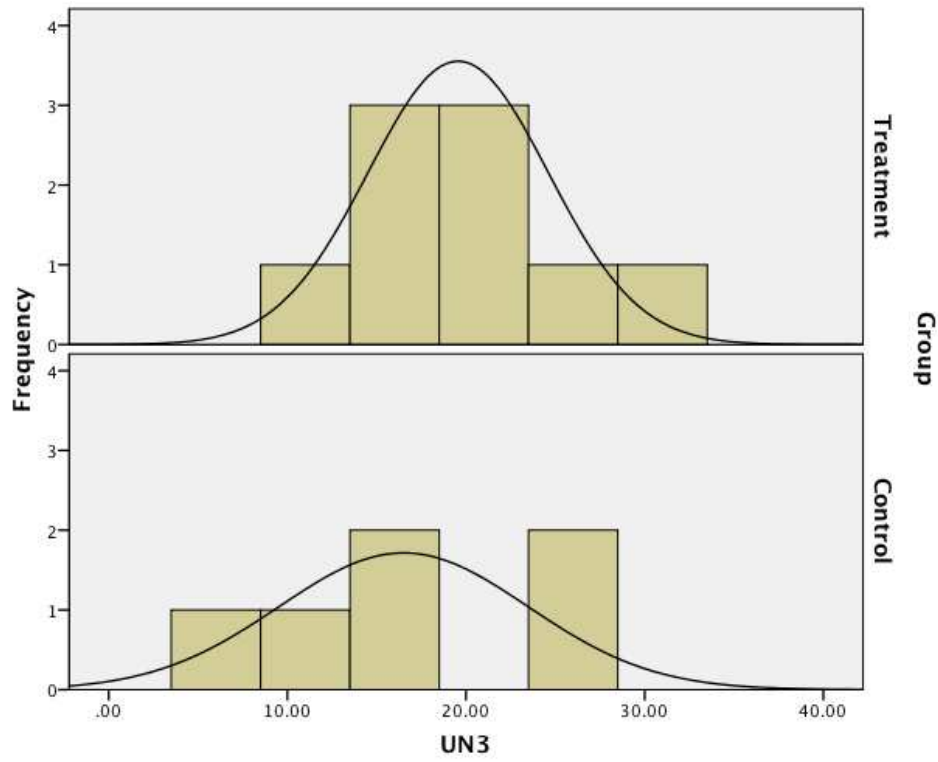


Figure A4b.xi: UN3

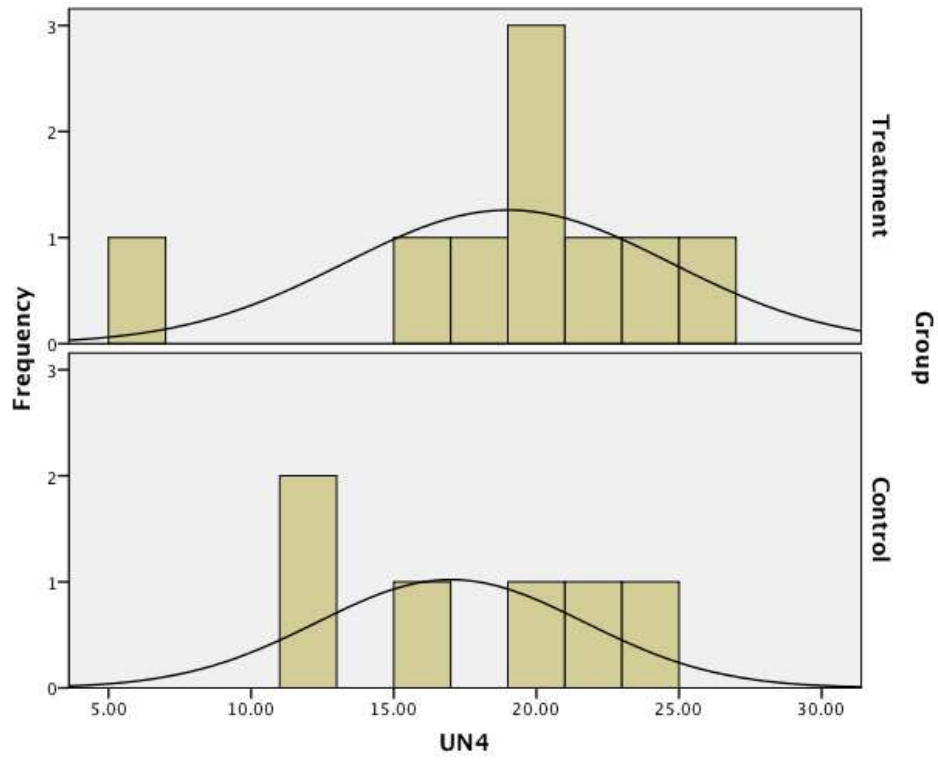


Figure A4b.xii: UN4

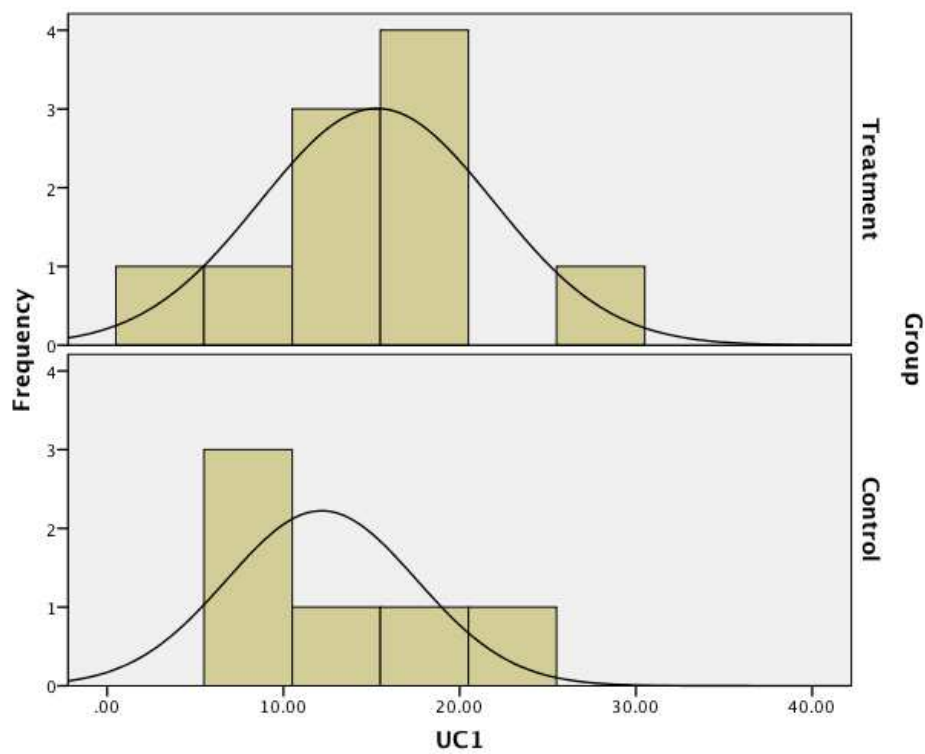


Figure A4b.xiii: UC1

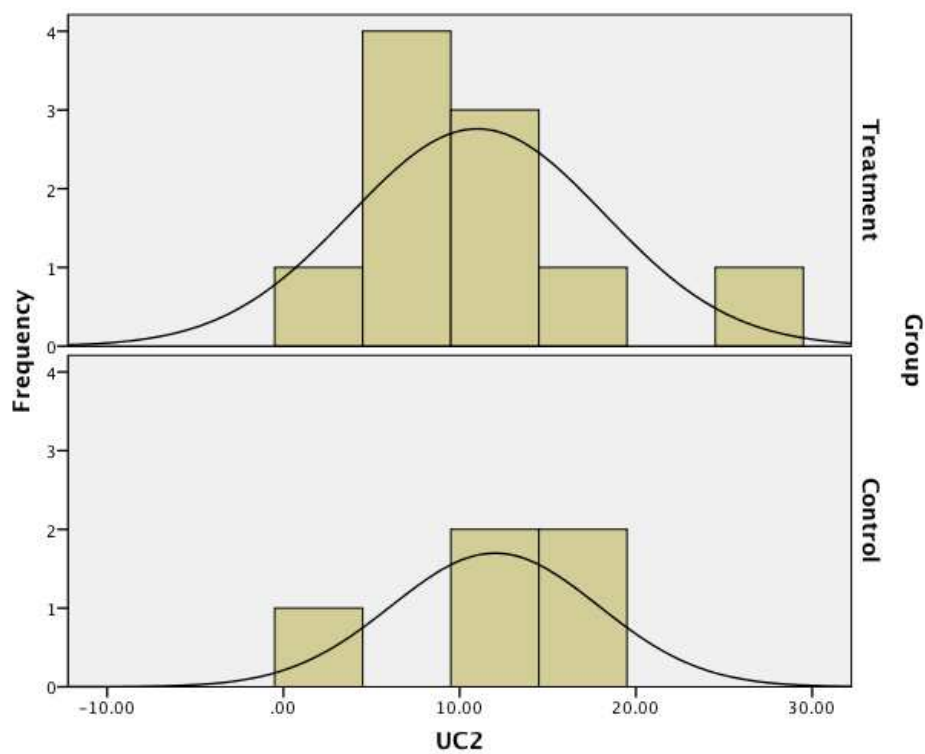


Figure A4b.xiv: UC2

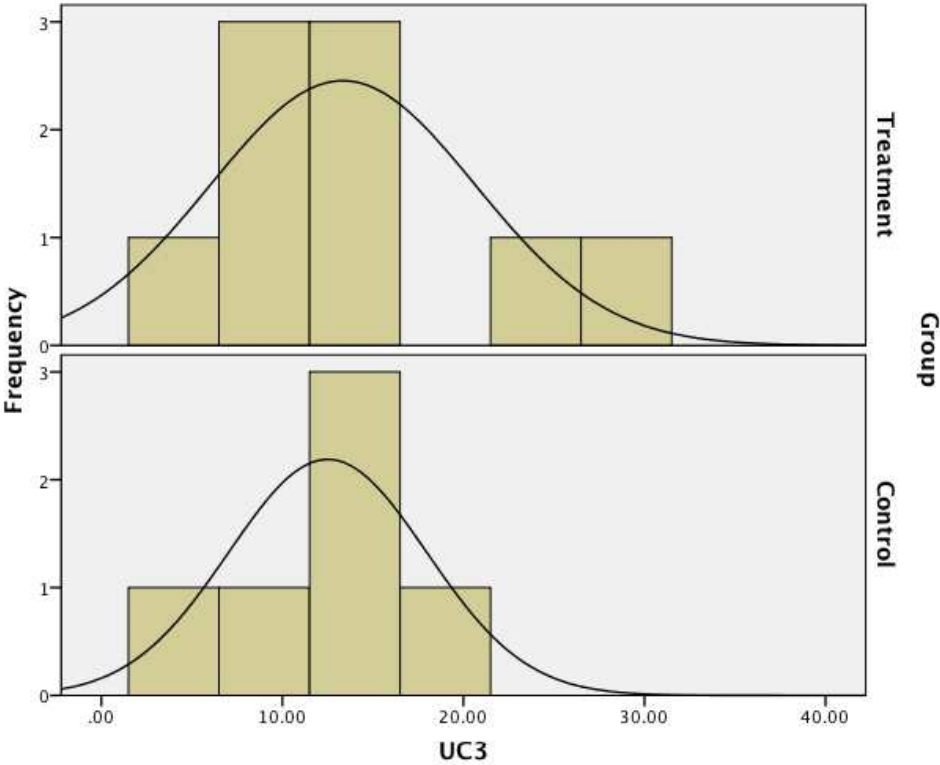


Figure A4b.xv: UC3

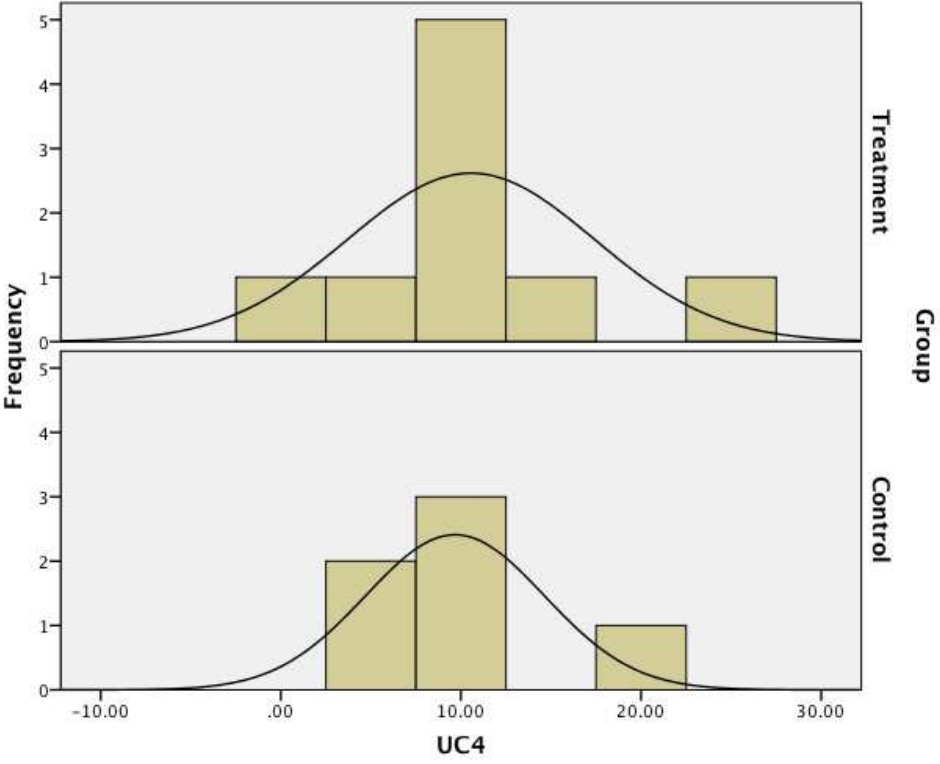


Figure A4b.xvi: UC4

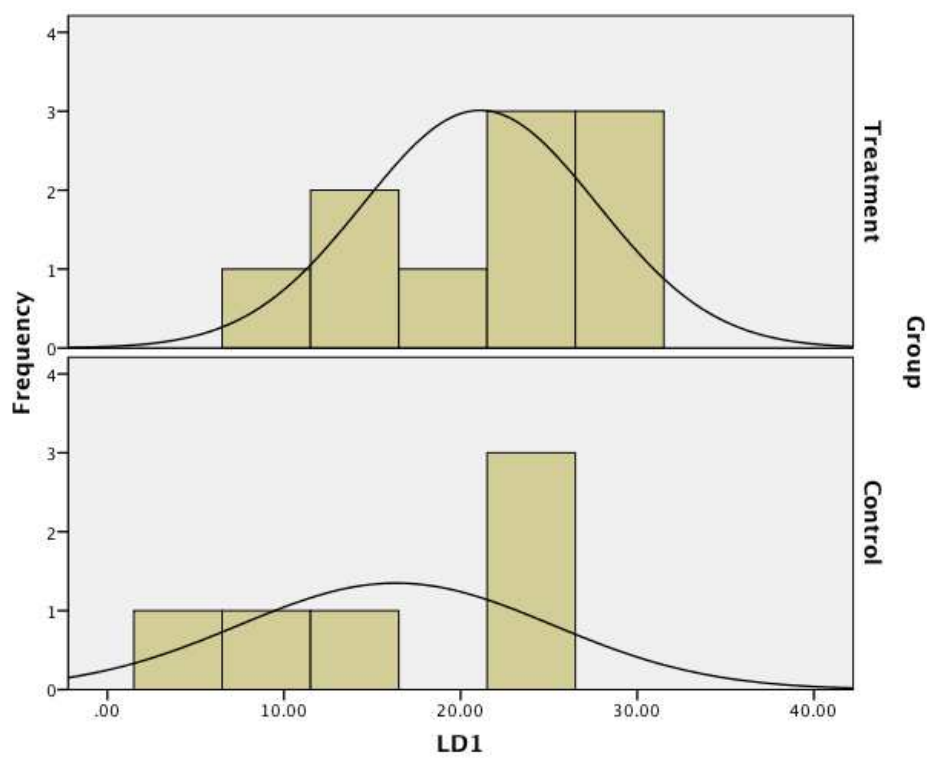


Figure A4b.xvii: LD1

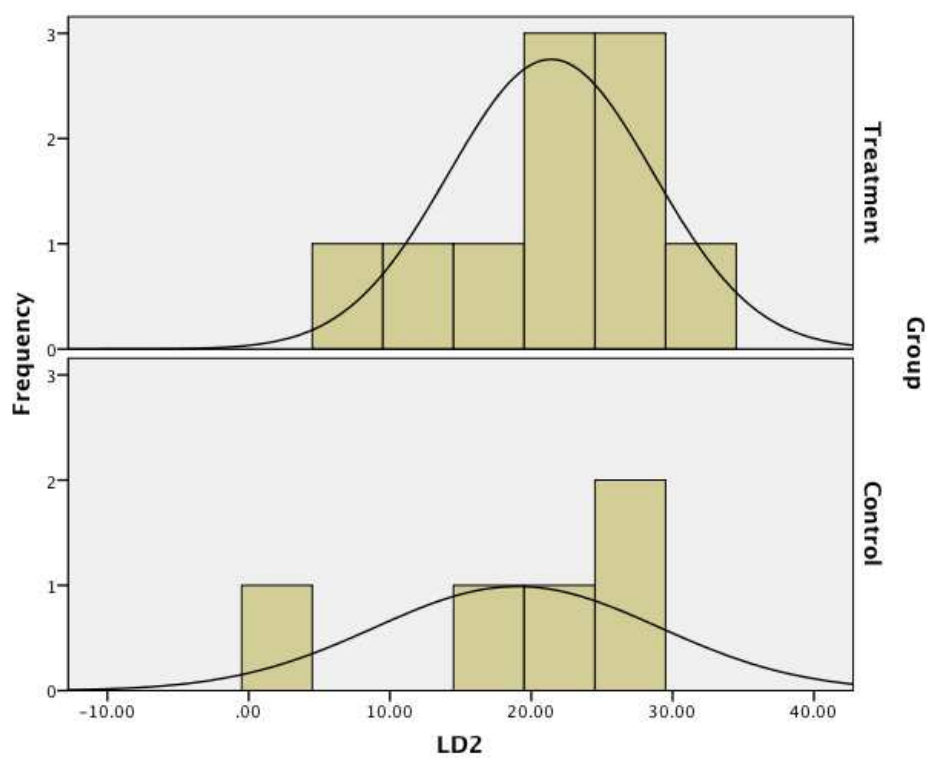


Figure A4b.xviii: LD2

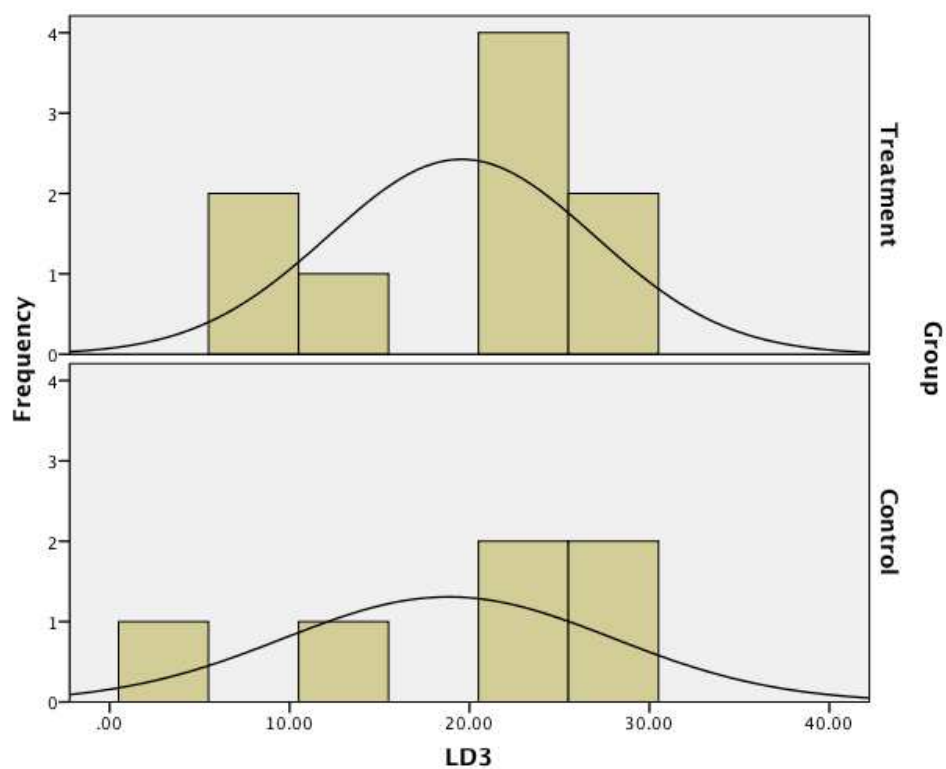


Figure A4b.xix: LD3

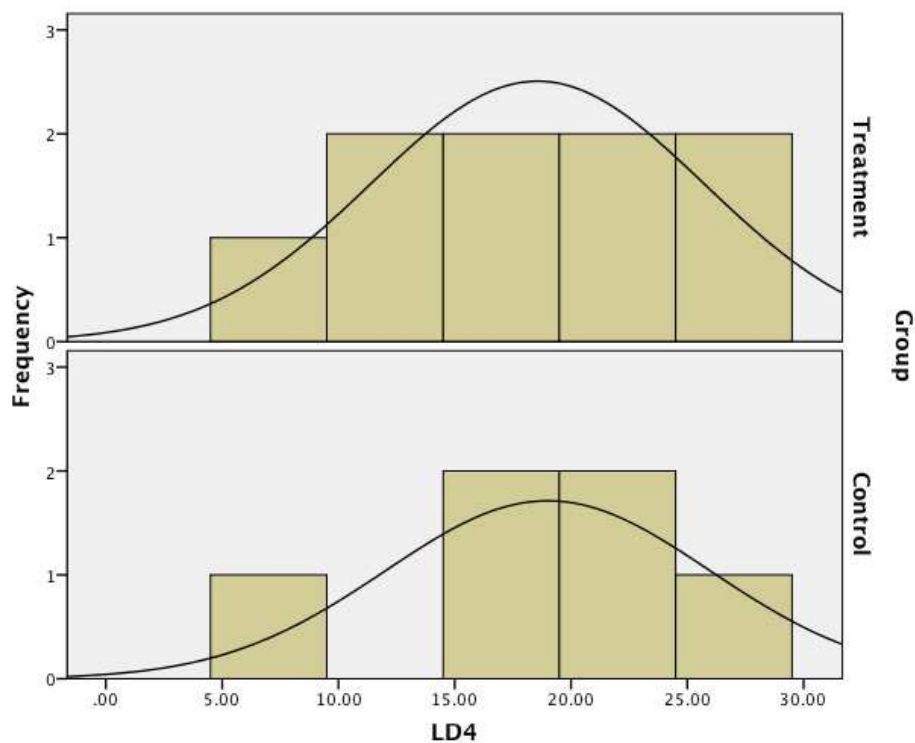


Figure A4b.xx: LD4

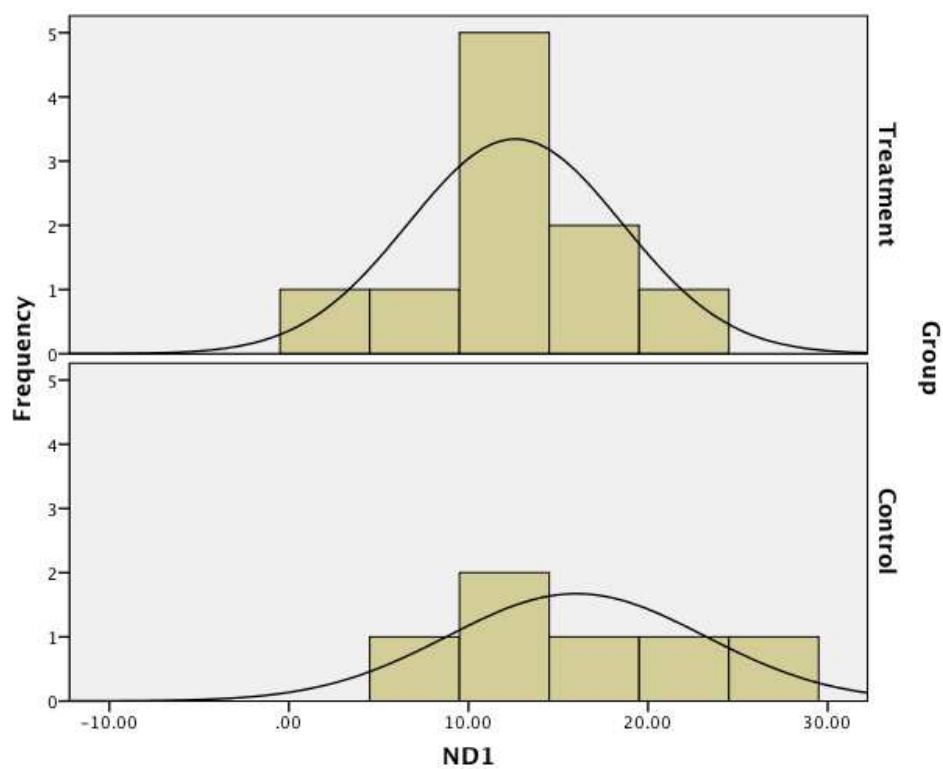


Figure A4b.xxi: ND1

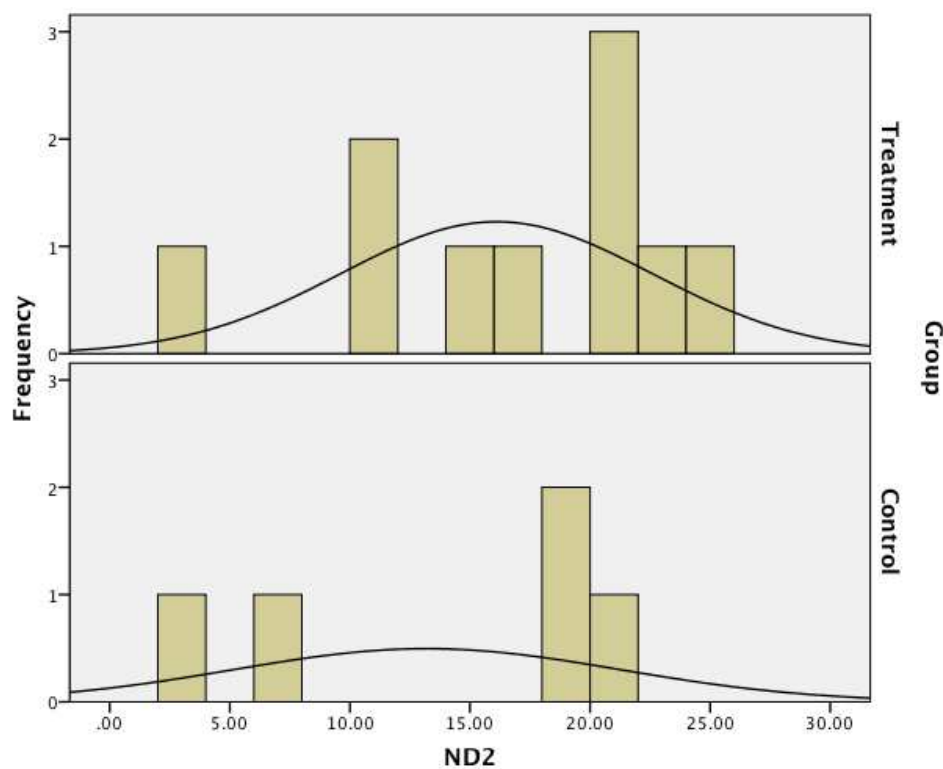


Figure A4b.xxii: ND2

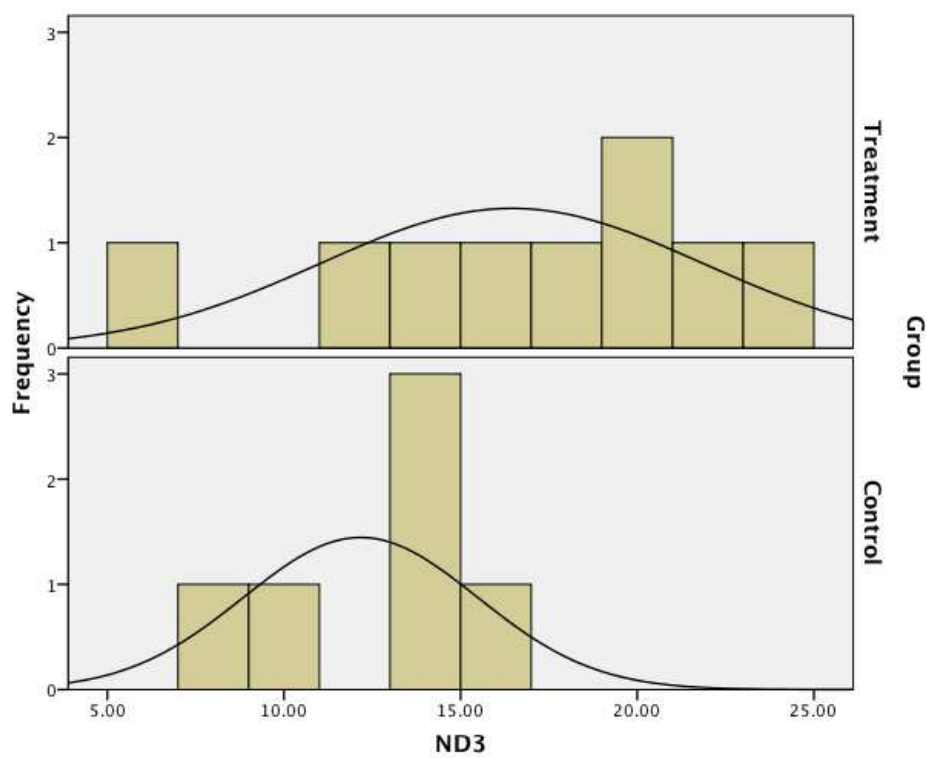


Figure A4b.xxiii: ND3

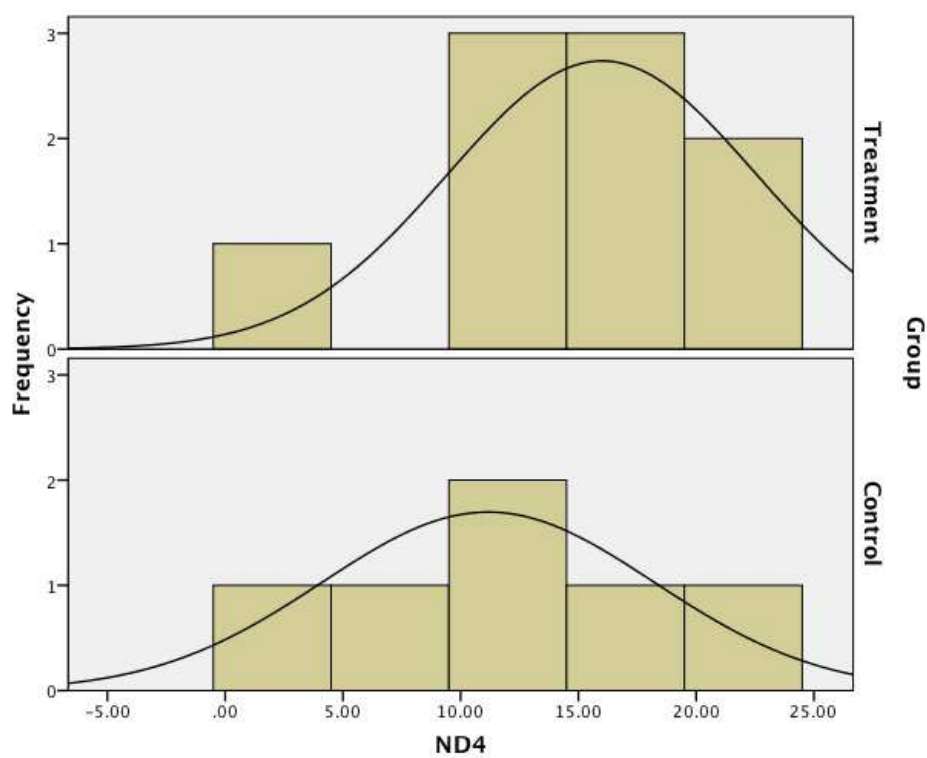


Figure A4b.xxiv: ND4

Appendix 4c: Treatment effect across time and by groups

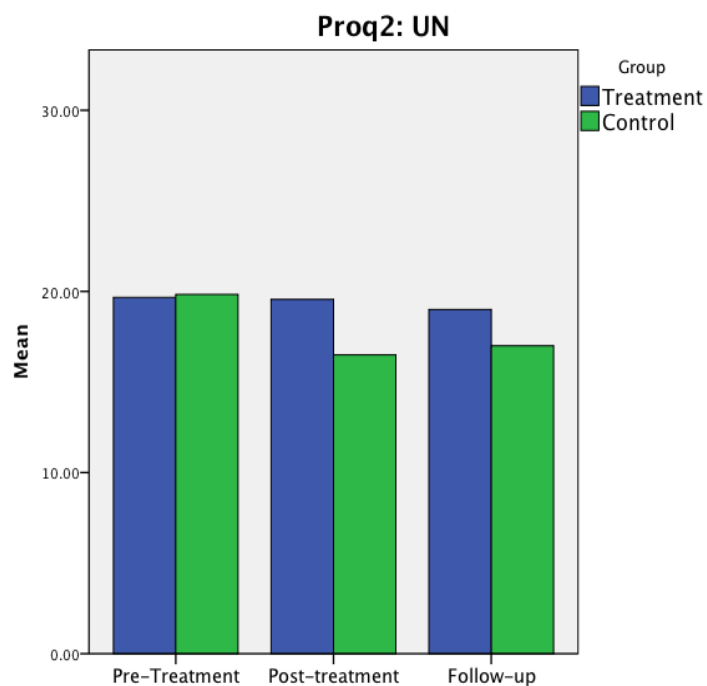


Figure A4c.i: Upper Neutral (UN) treatment and control across time.

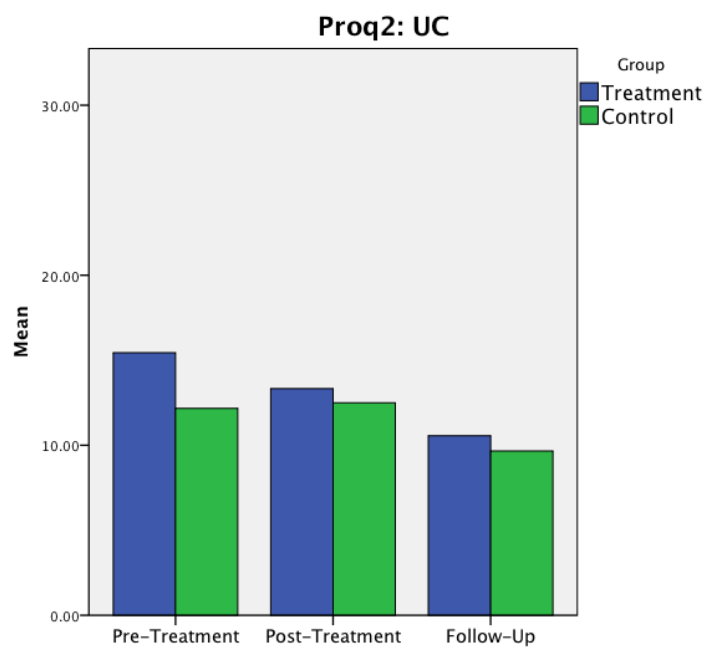


Figure A4c.ii: Upper Close (UC) treatment and control across time.

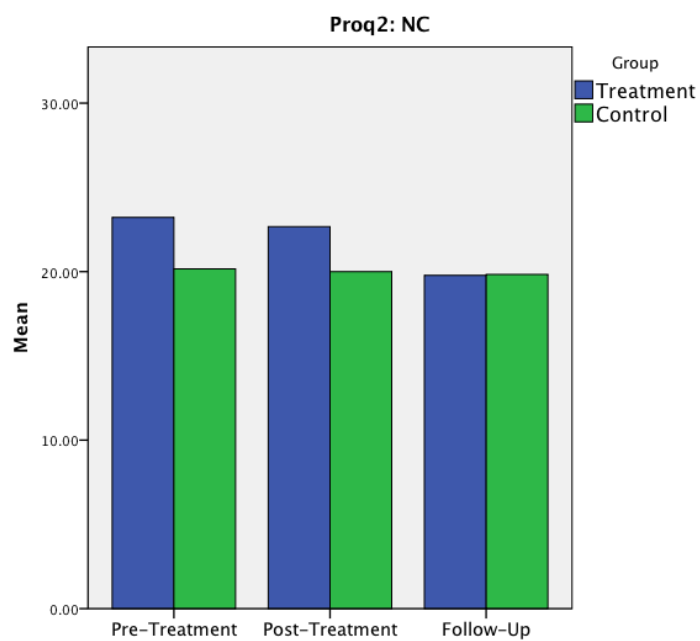


Figure A4c.iii: Neutral Close (NC) treatment and control across time.

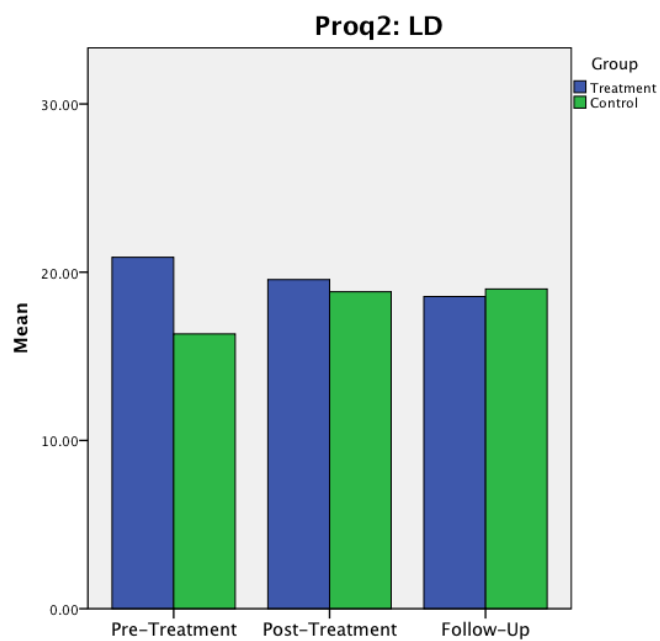


Figure A4c.iv: Lower Distant (LD) treatment and control across time.

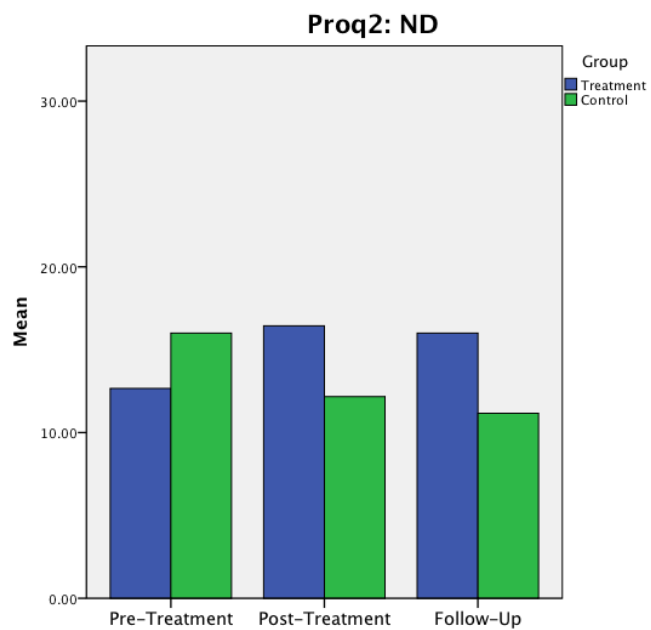


Figure A4c.v: Neutral Distant (ND) treatment and control across time.

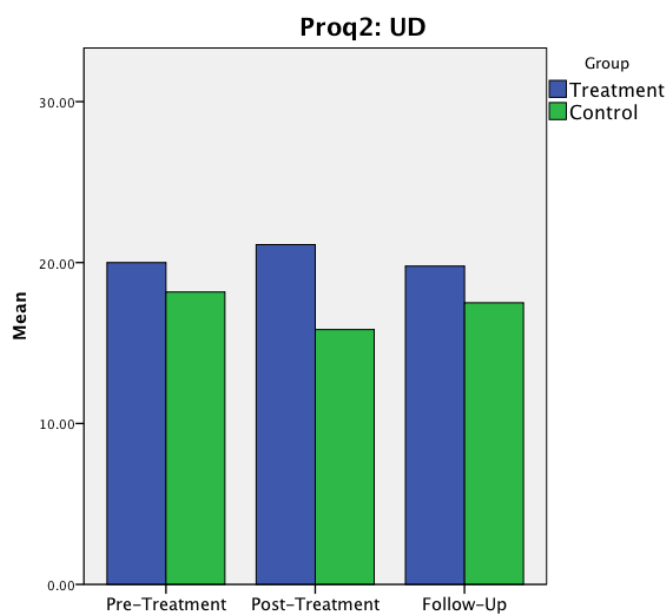


Figure A4c.vi: Upper Distant (UD) treatment and control across time.

Appendix 4d: Distribution of data, secondary measures MDI, BES, CIRCLE (checking for normality)

MDI domains at time points 1, 2 and 3 respectively by Groups

4d1: Disengagement

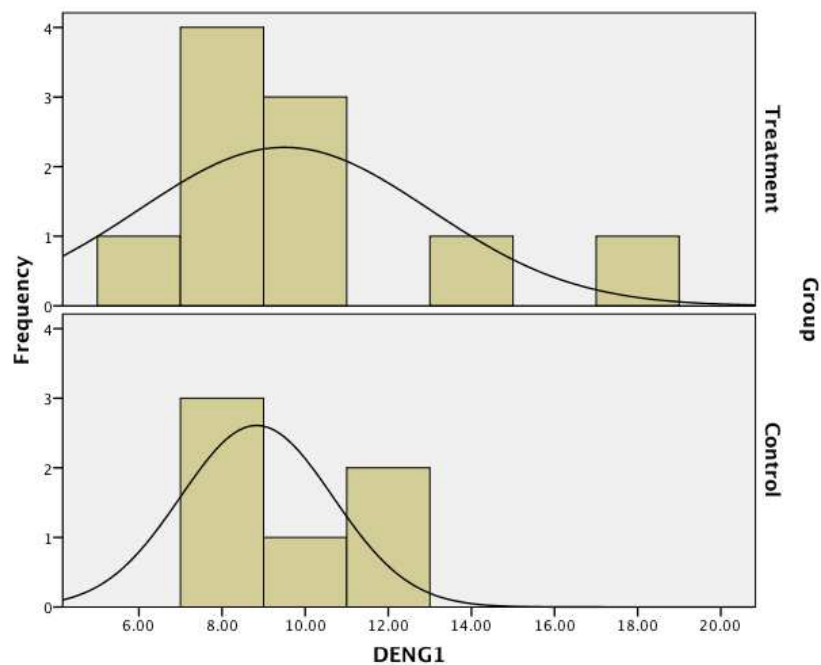


Figure A4d1.i: DENG1

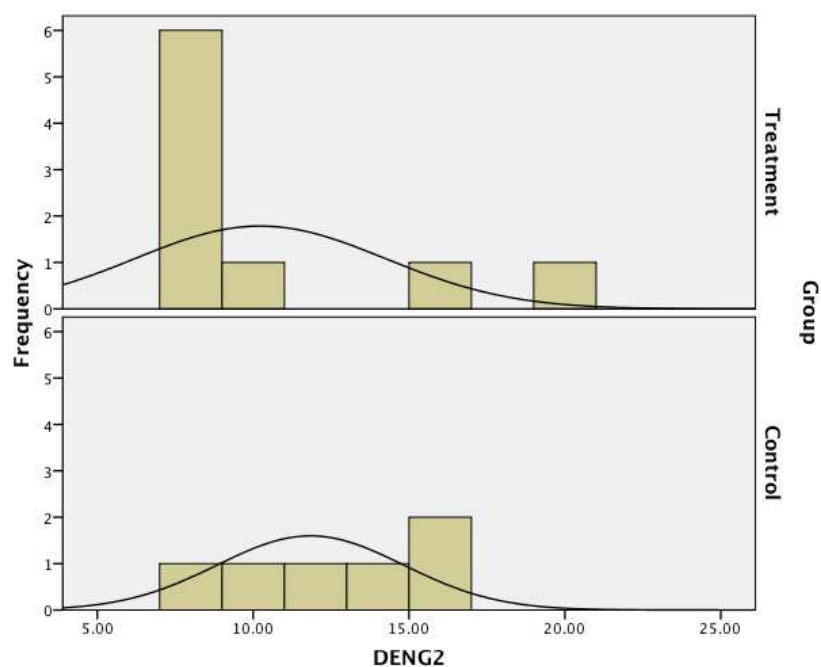


Figure A4d1.ii: DENG2

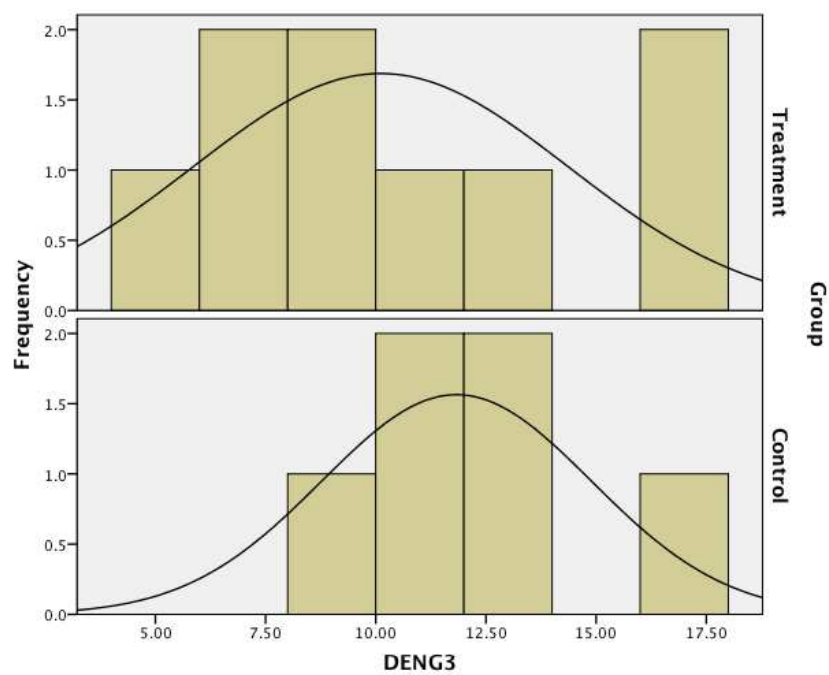


Figure A4d1.iii: DENG3

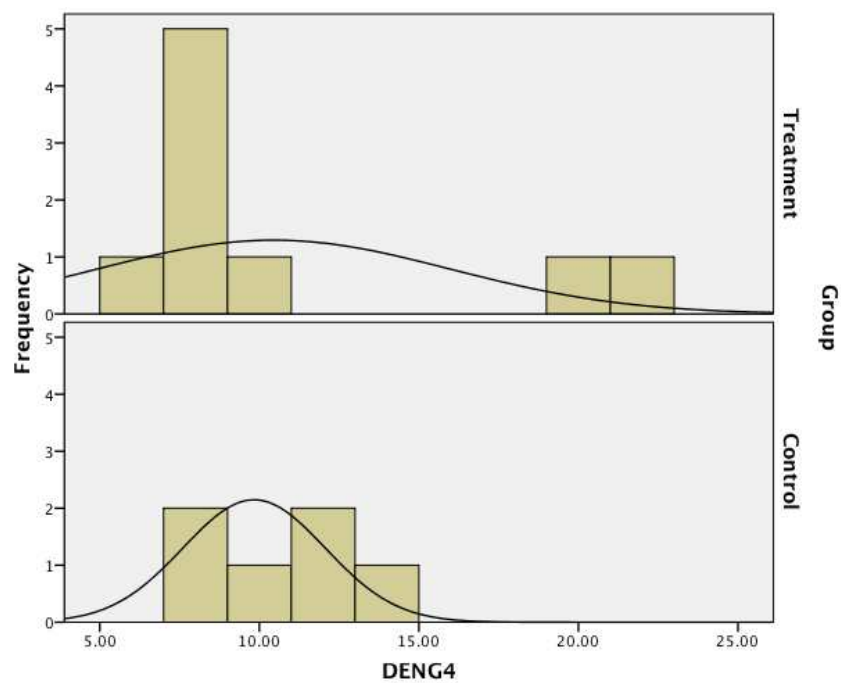


Figure A4d1.iv: DENG4

4d2: Emotional Constriction

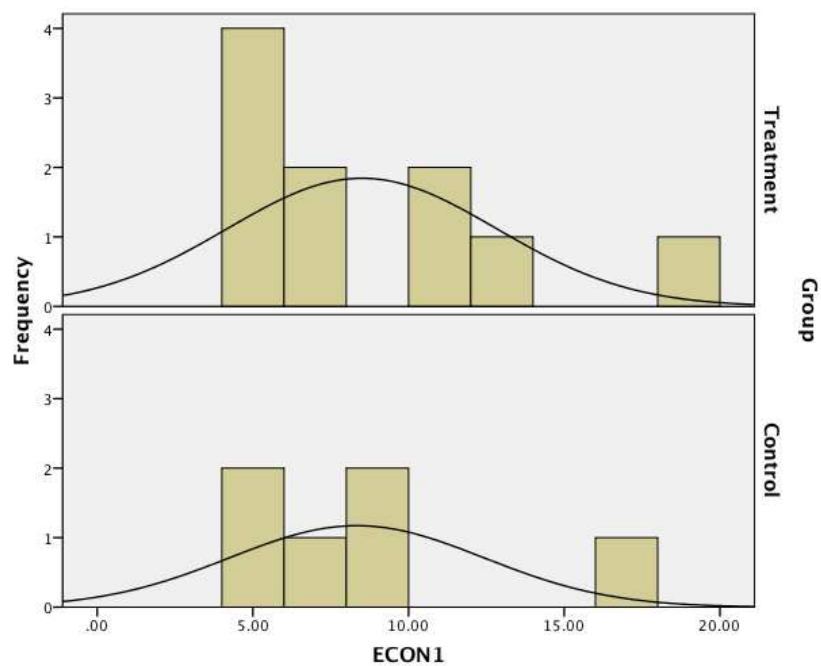


Figure A4d2.i: ECON1

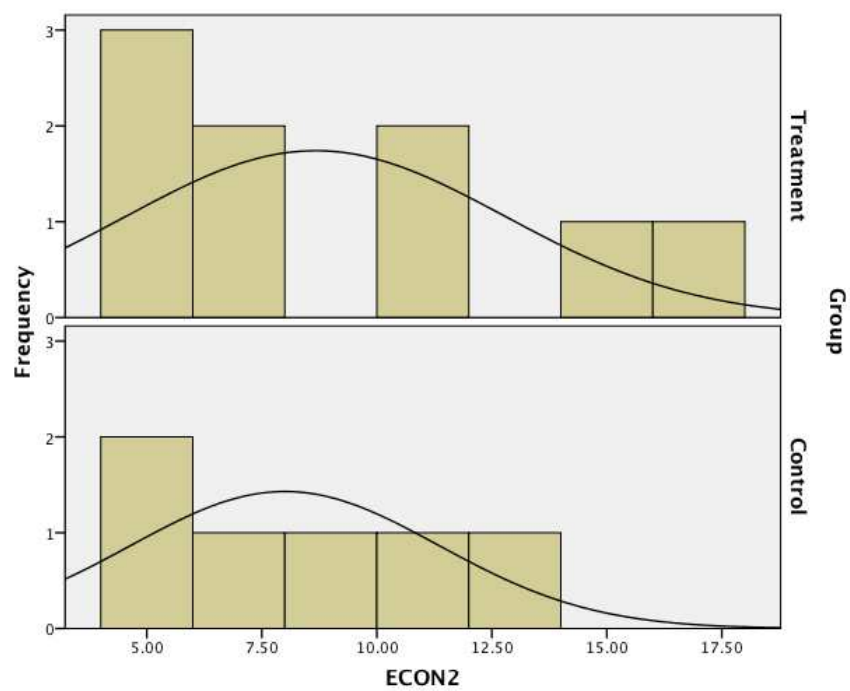


Figure A4d2.ii: ECON2

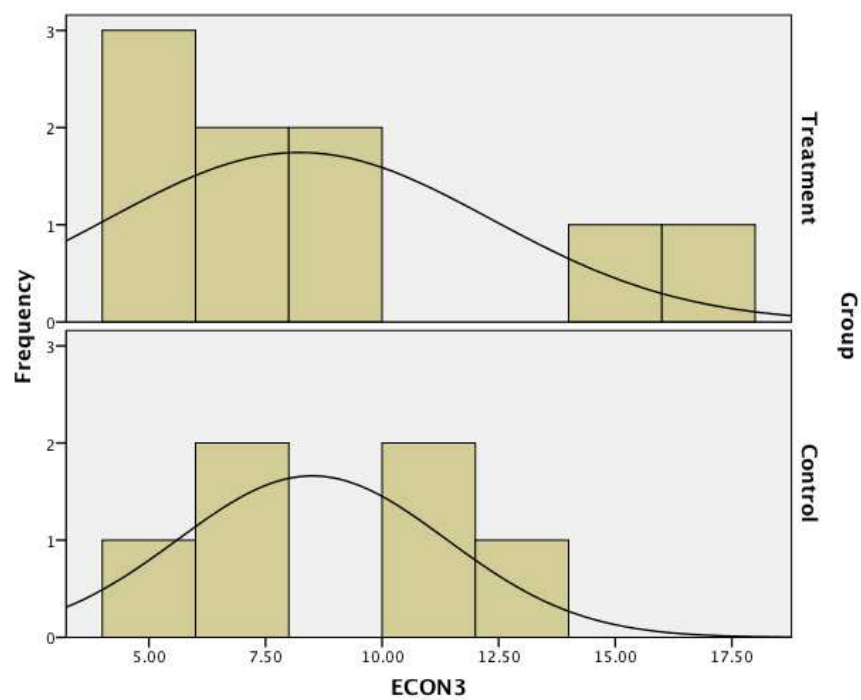


Figure A4d2.iii: ECON3

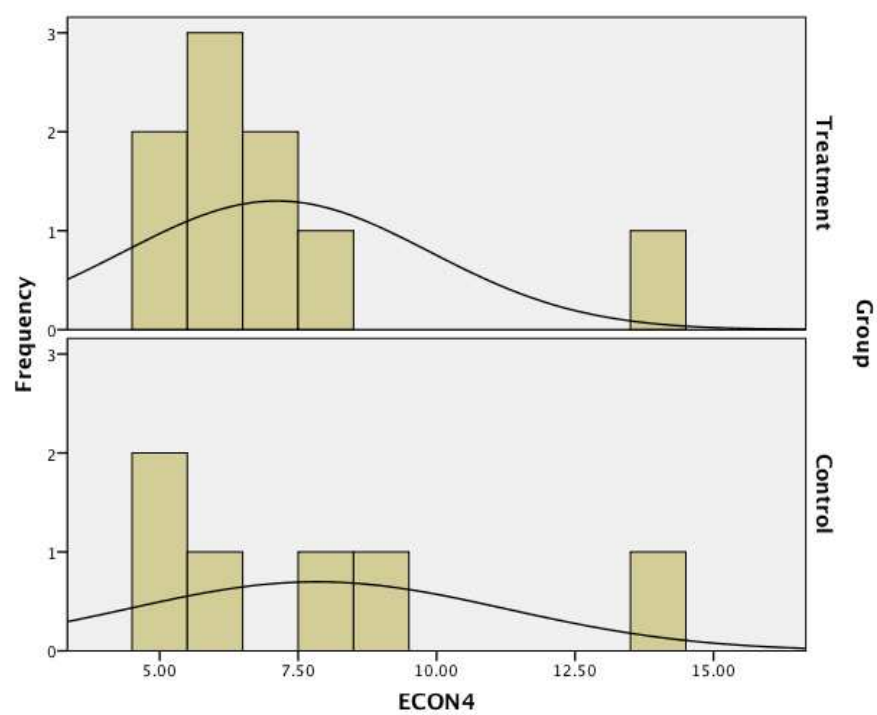


Figure A4d2.iv: ECON4

BES domains at time points 1, 2 and 3 respectively by Groups

4d3: Cognitive empathy

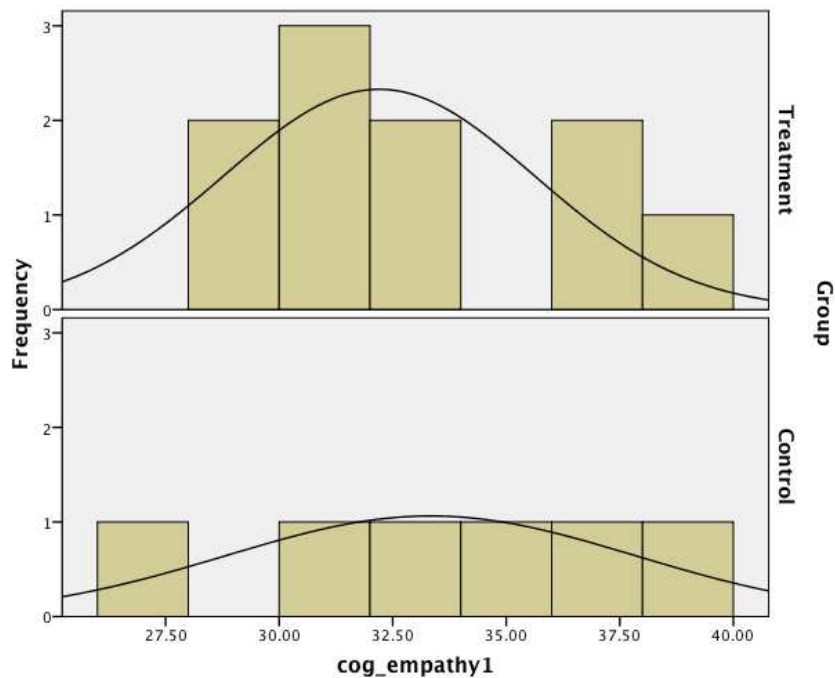


Figure A4d3.i: cog_emp1

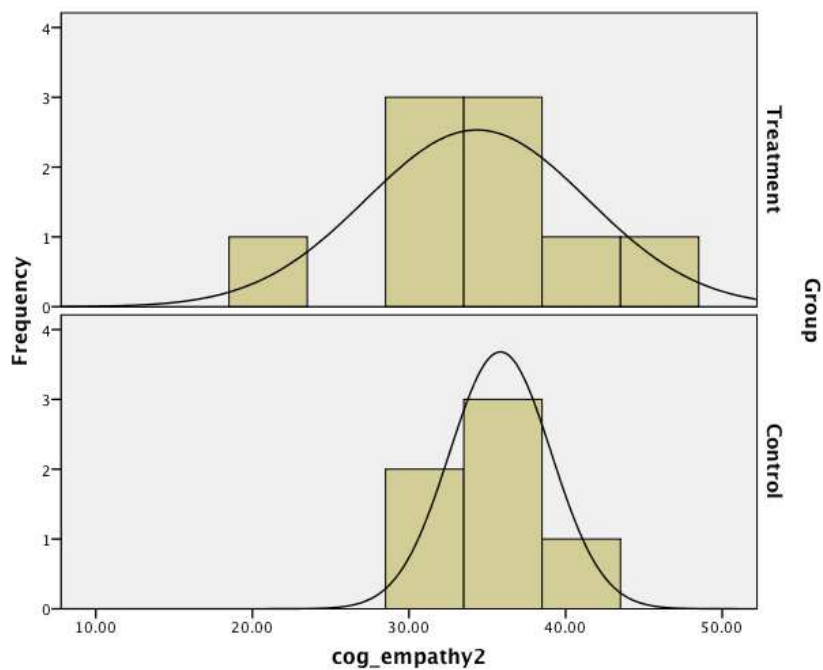
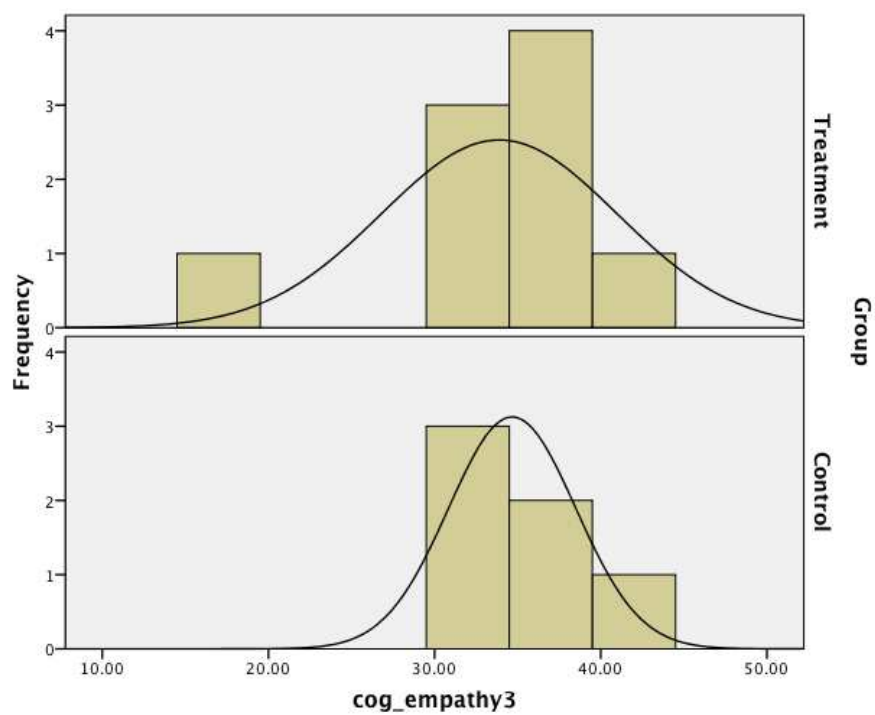
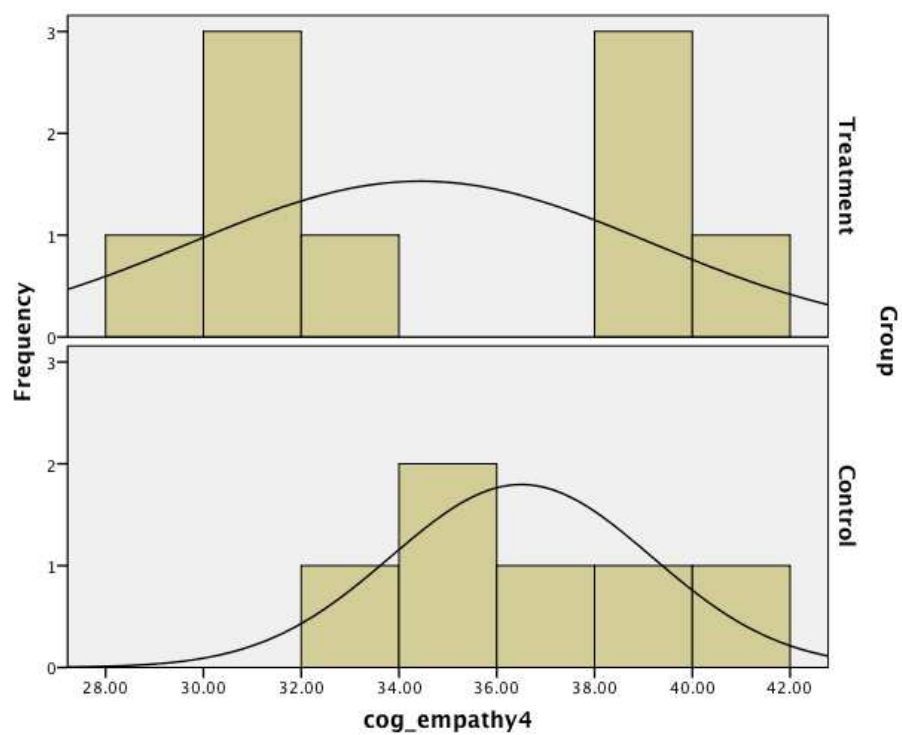


Figure A4d3.ii: cog_emp2

Figure A4d3.iii: *cog_empathy3*Figure A4d3.iv: *cog_empathy4*

4d4: Affective Empathy domain

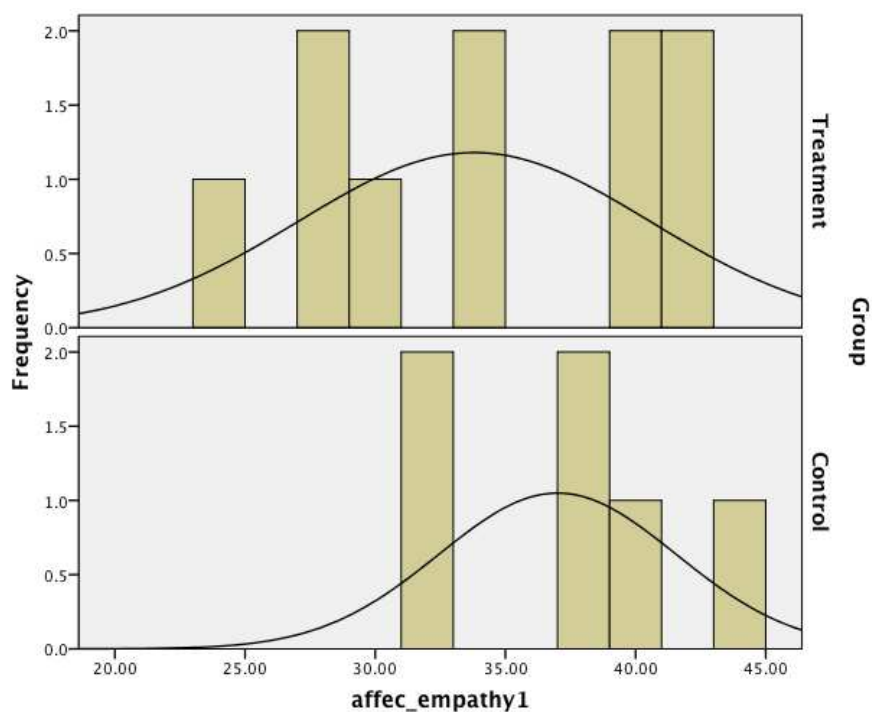


Figure A4d4.i: affec_empathy1

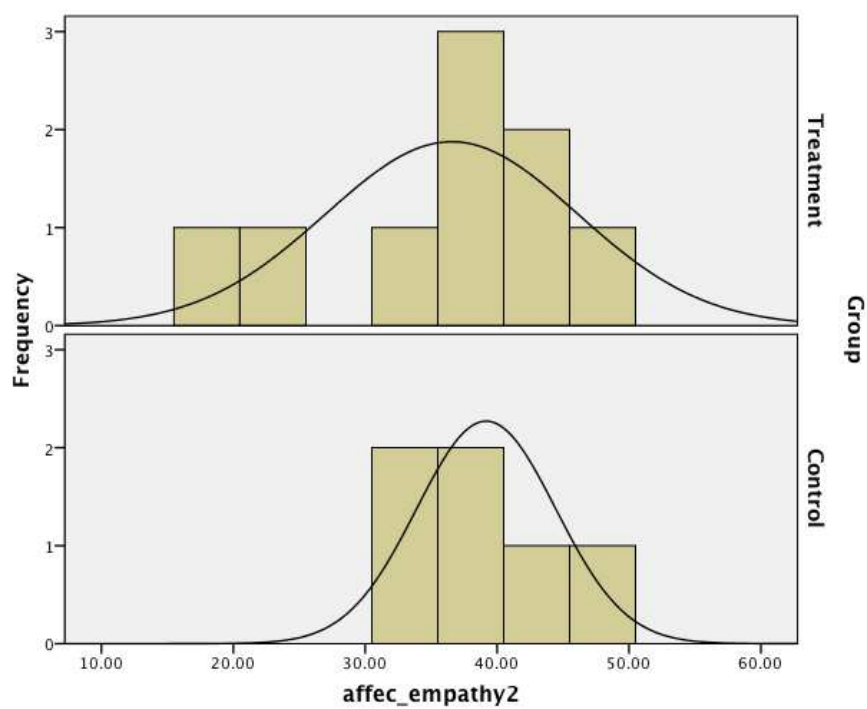


Figure A4d4.ii: affec_empathy2

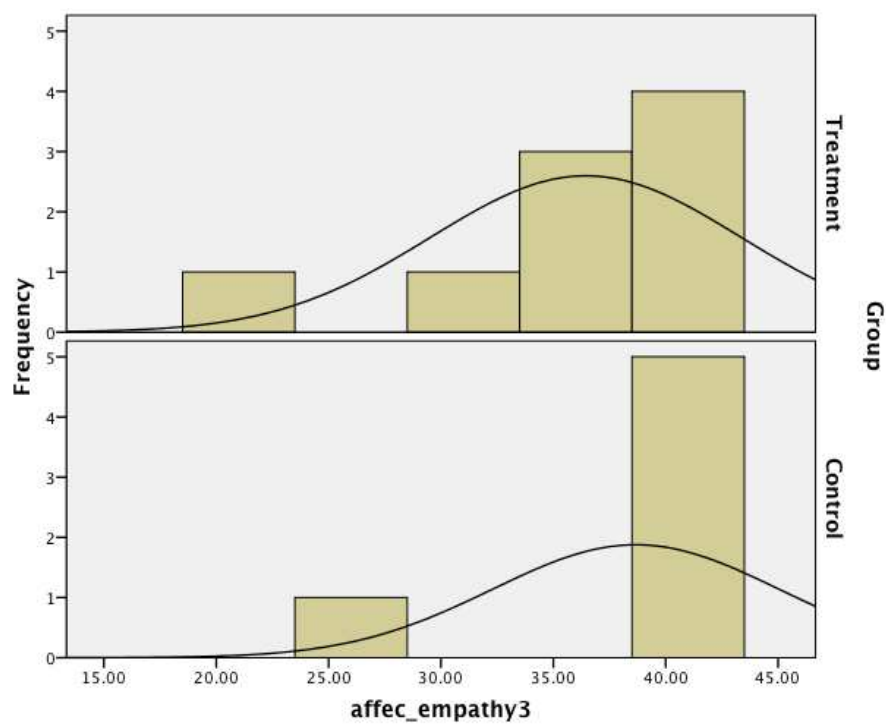


Figure A4d4.iii: affec_emp3

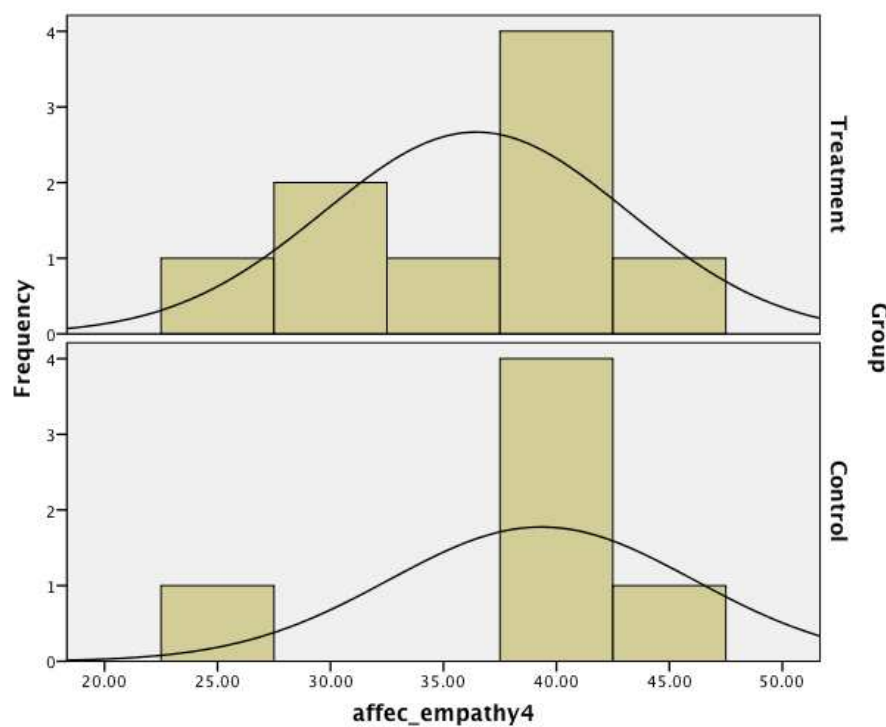


Figure A4d4.iv: affec_emp4

4d5: TOTAL score

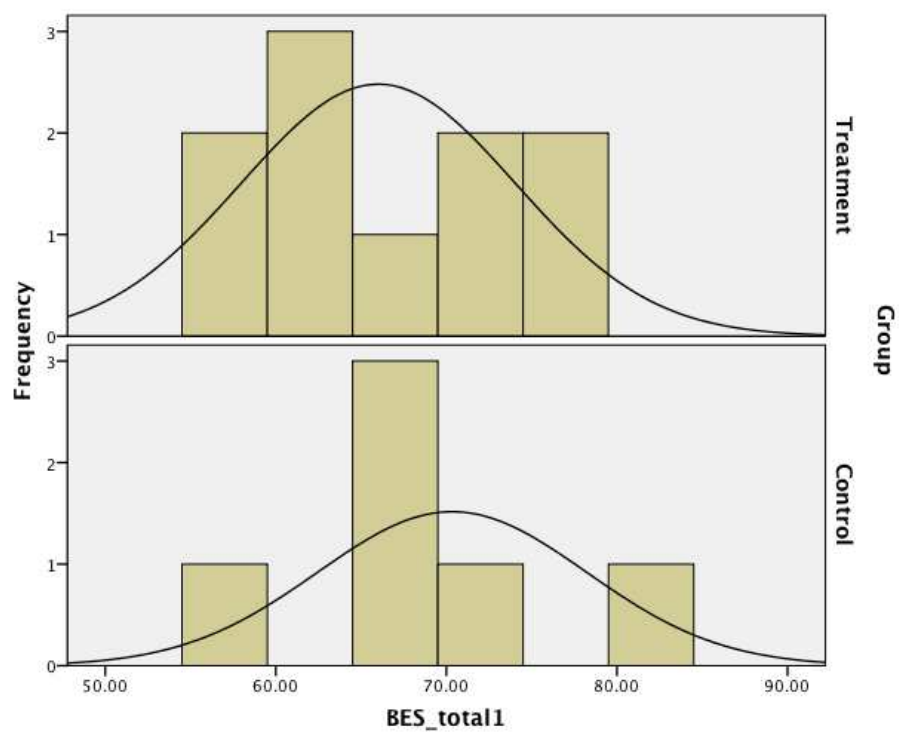


Figure A4d5.i: BES_total1

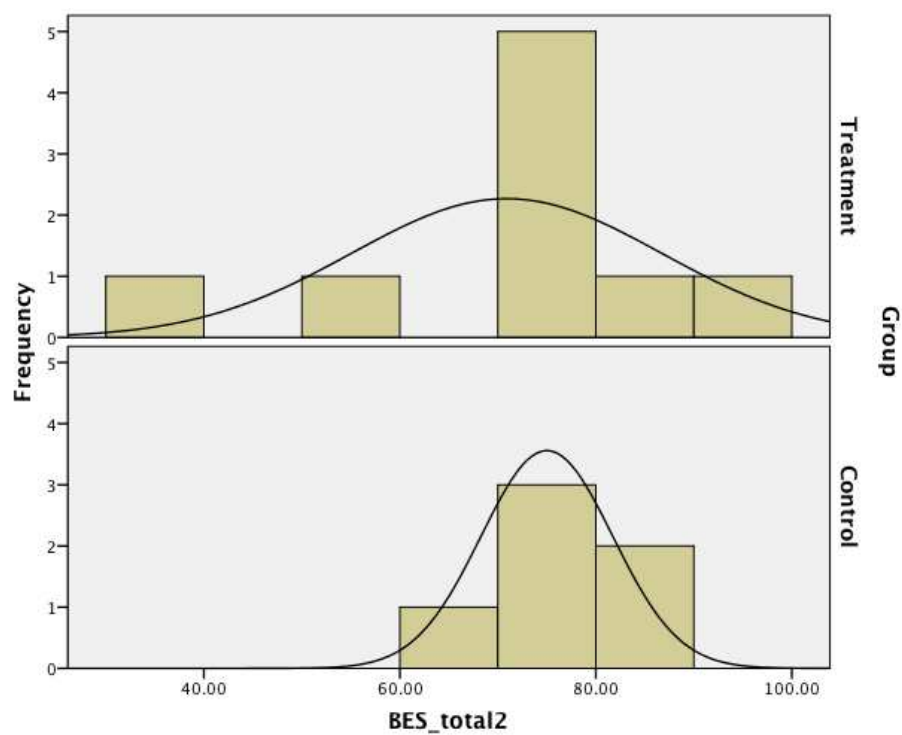


Figure A4d5.ii: BES_total2

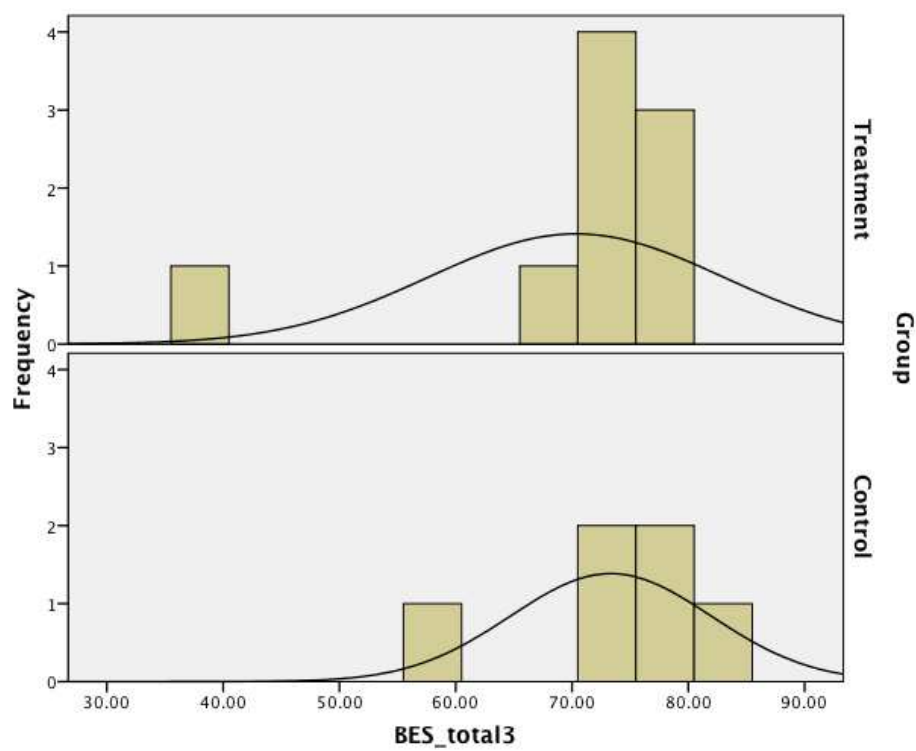


Figure A4d5.iii: BES_total3

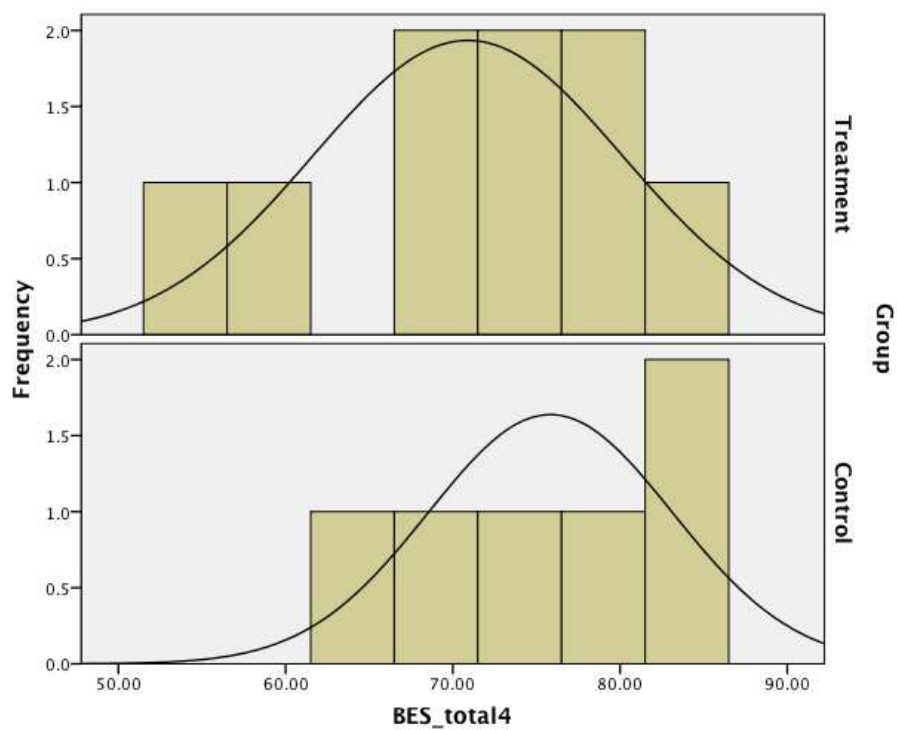


Figure A4d5.iv: BES_total4

CIRCLE domains at time points 1, 2 and 3 respectively by Groups

4d6: Hostile

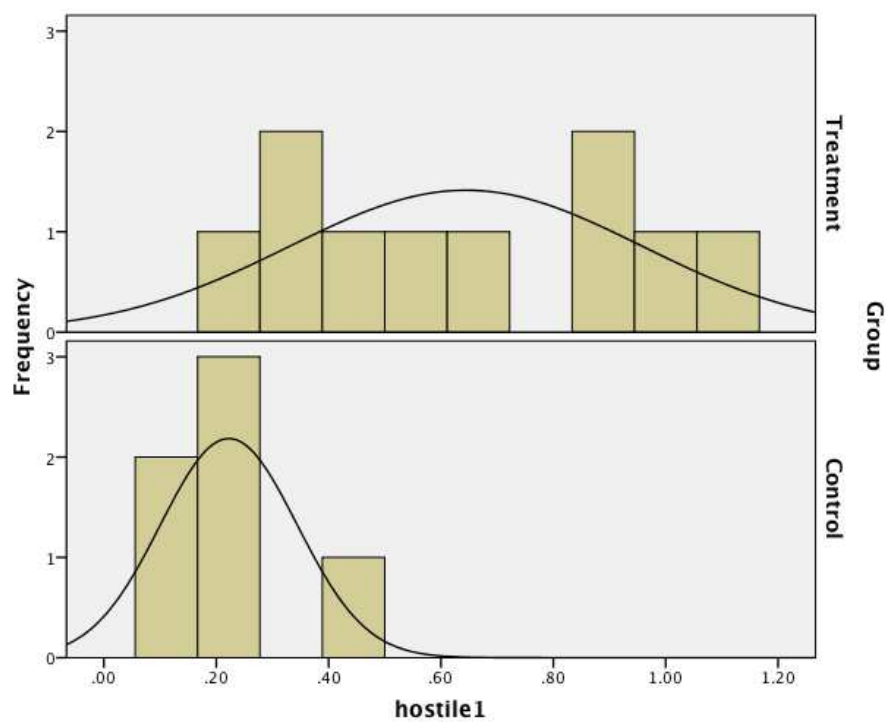


Figure A4d6.i: hostile1

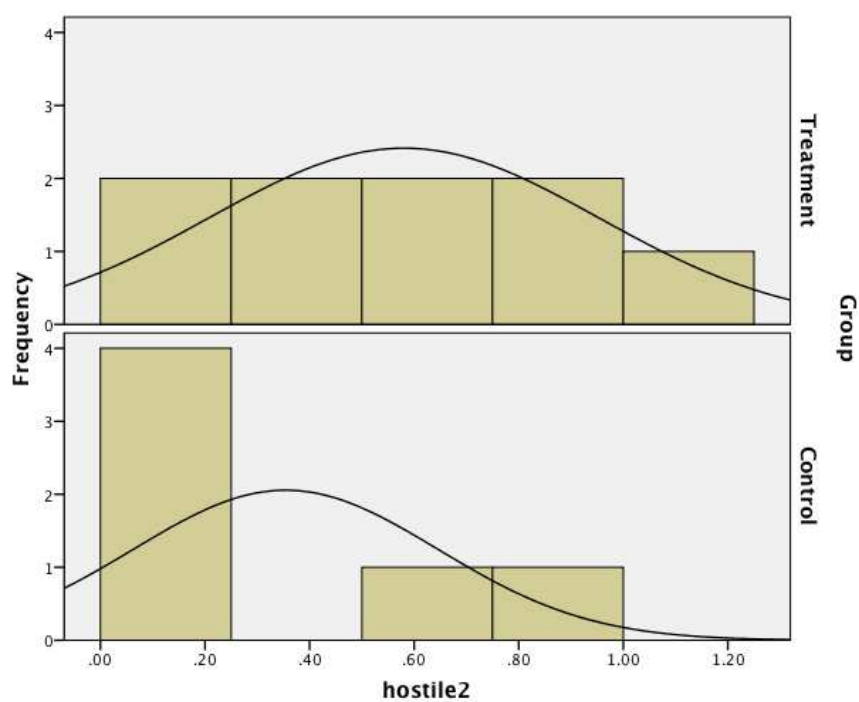


Figure A4d6.ii: hostile2

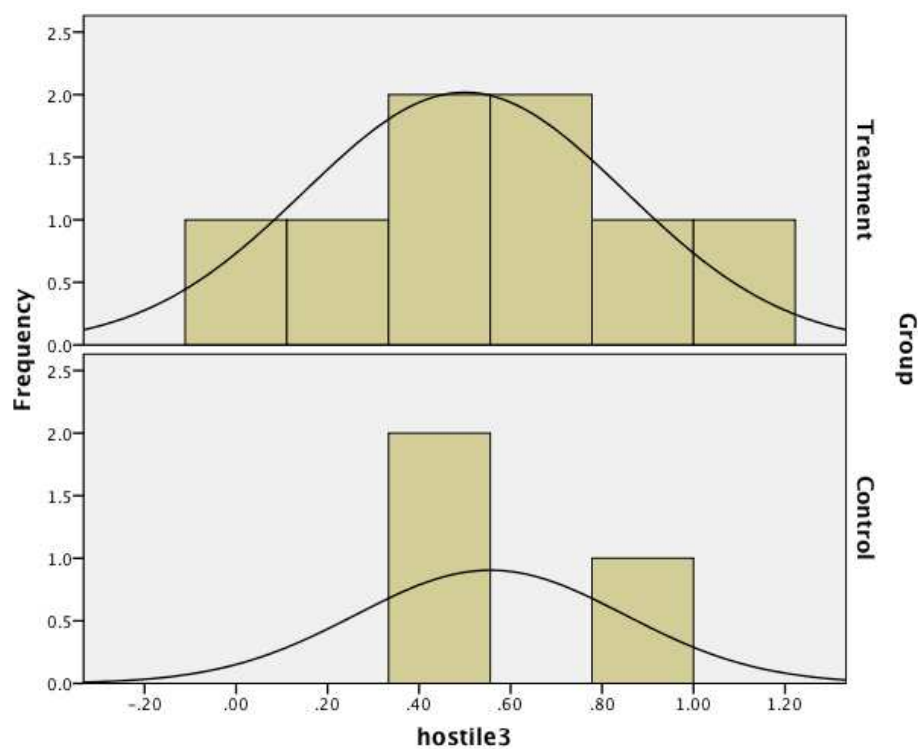


Figure A4d6.iii: hostile3

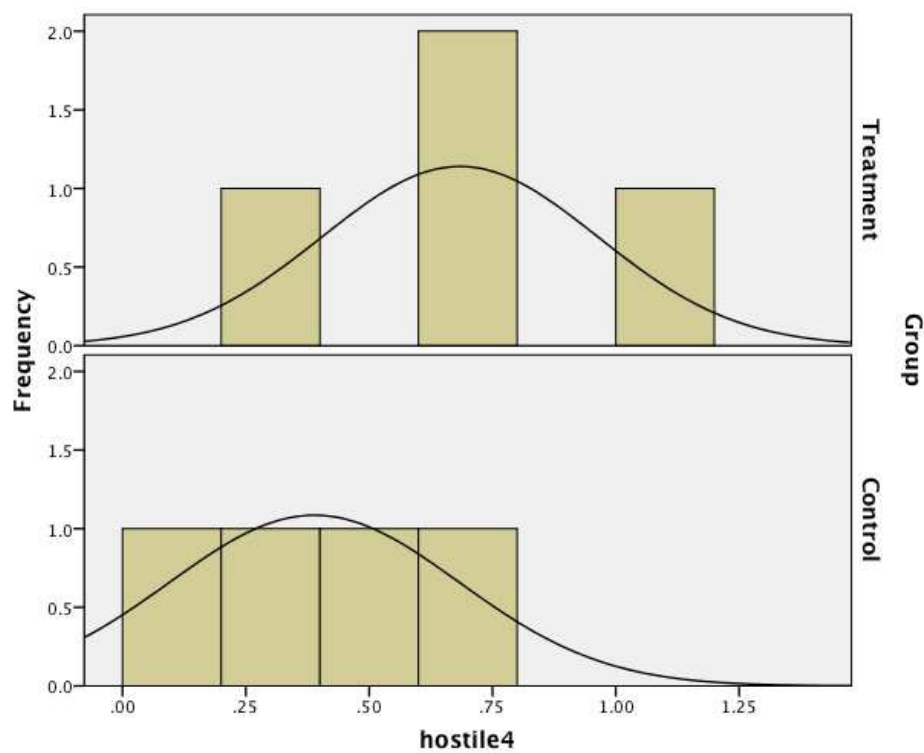


Figure A4d6.iv: hostile4

4d7: Withdrawn

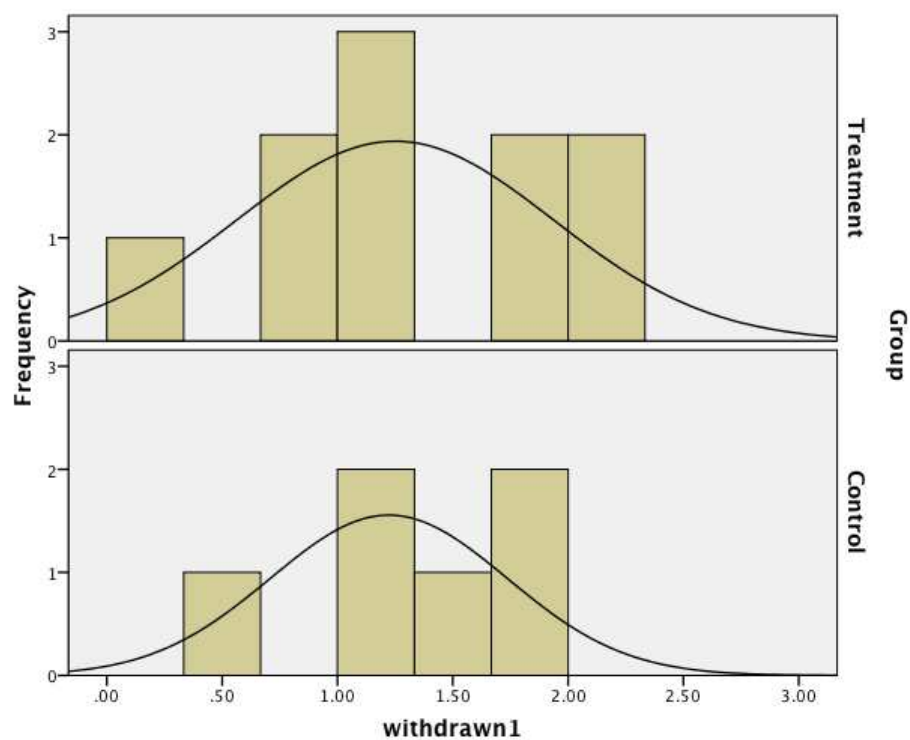


Figure A4d7.i: withdrawn1

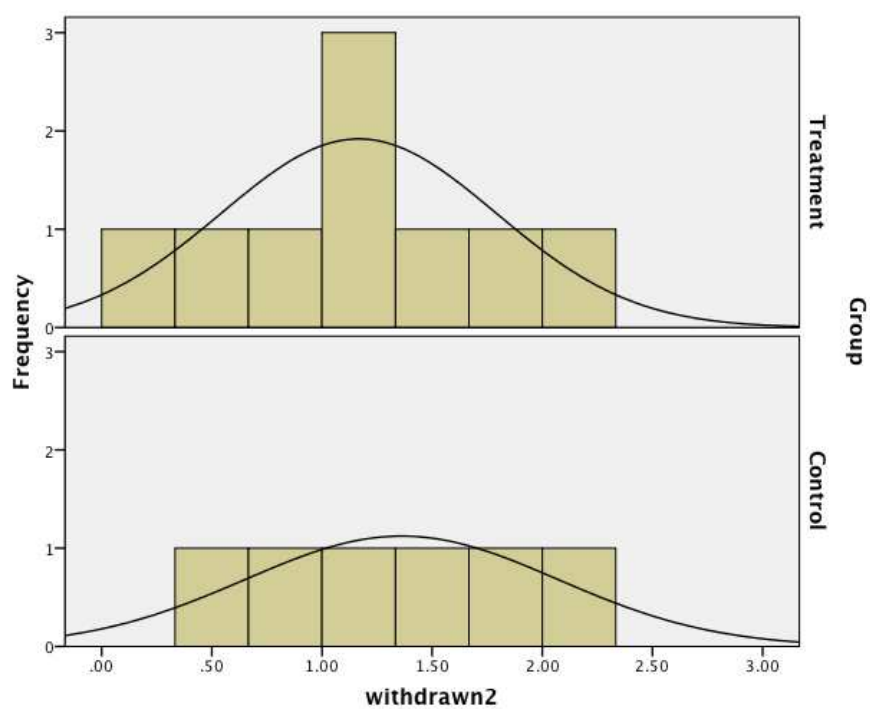


Figure A4d7.ii: withdrawn2

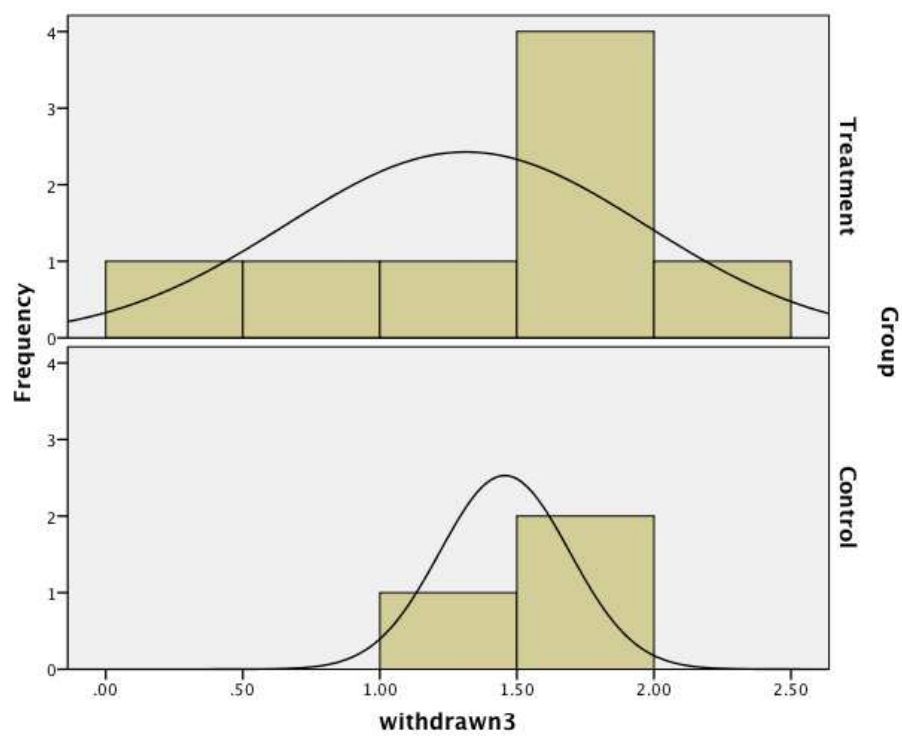


Figure A4d7.iii: withdrawn3

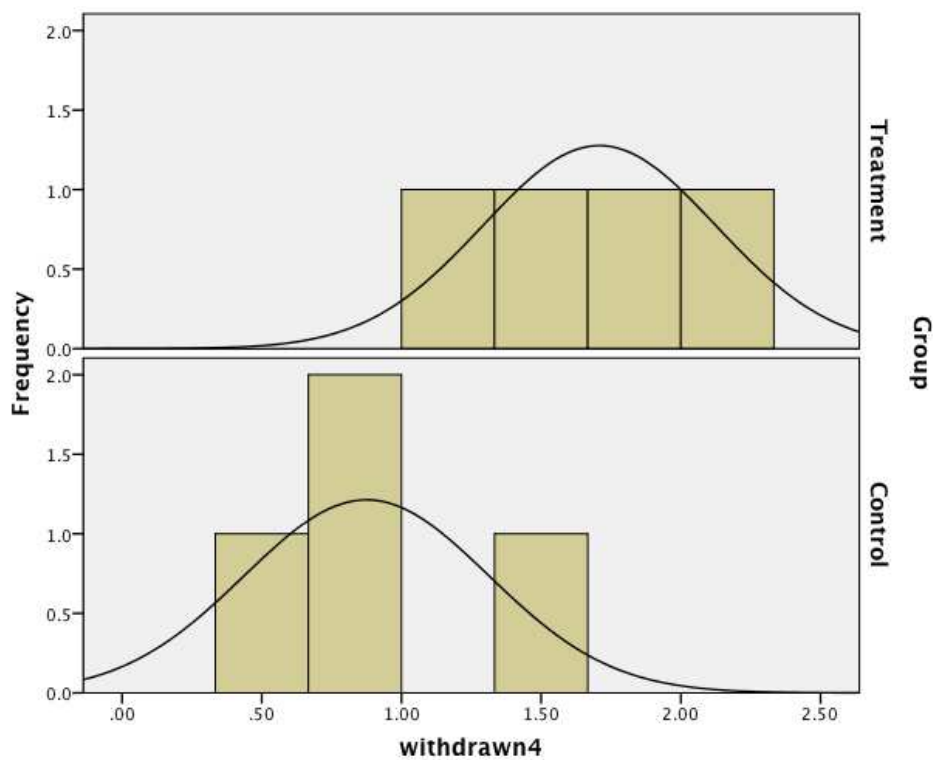


Figure A4d7.iv: withdrawn4

4d8: Friendly

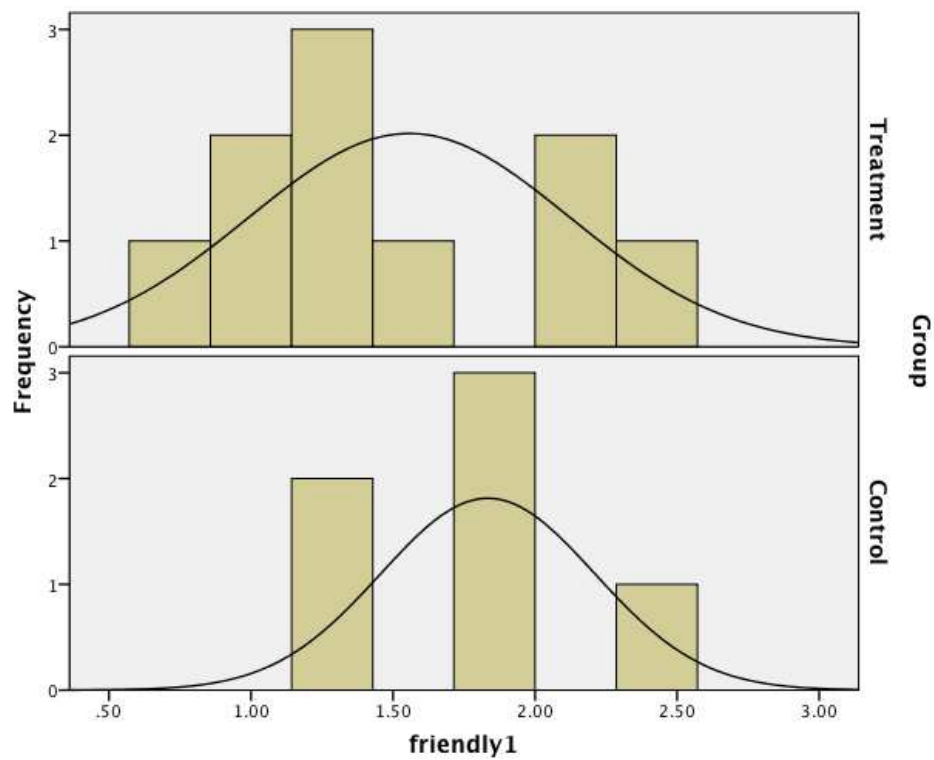


Figure A4d8.i: friendly1

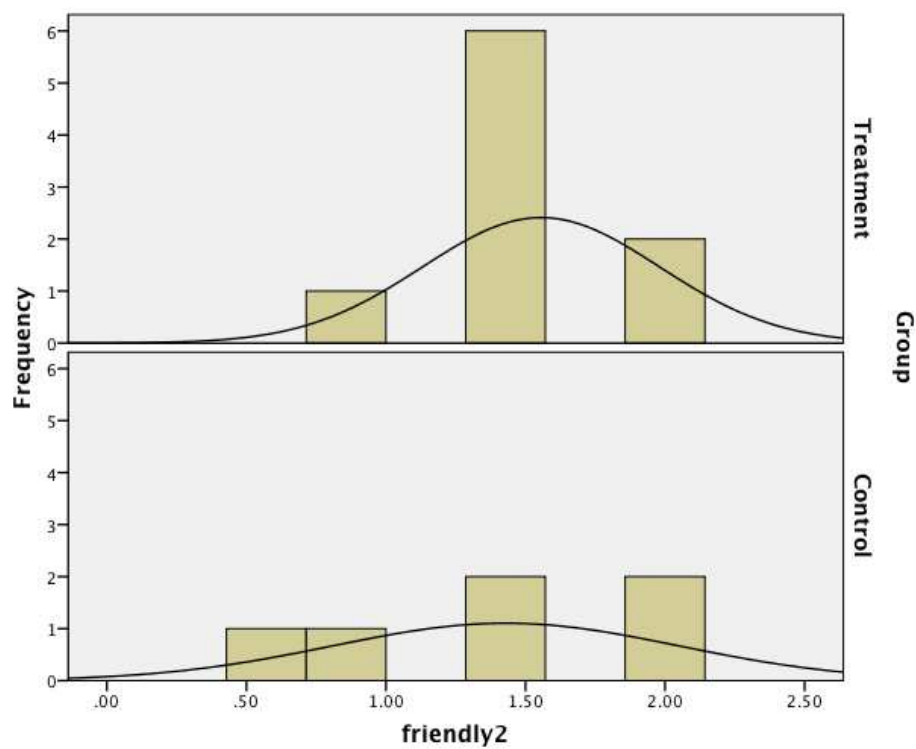


Figure A4d8.ii: friendly2

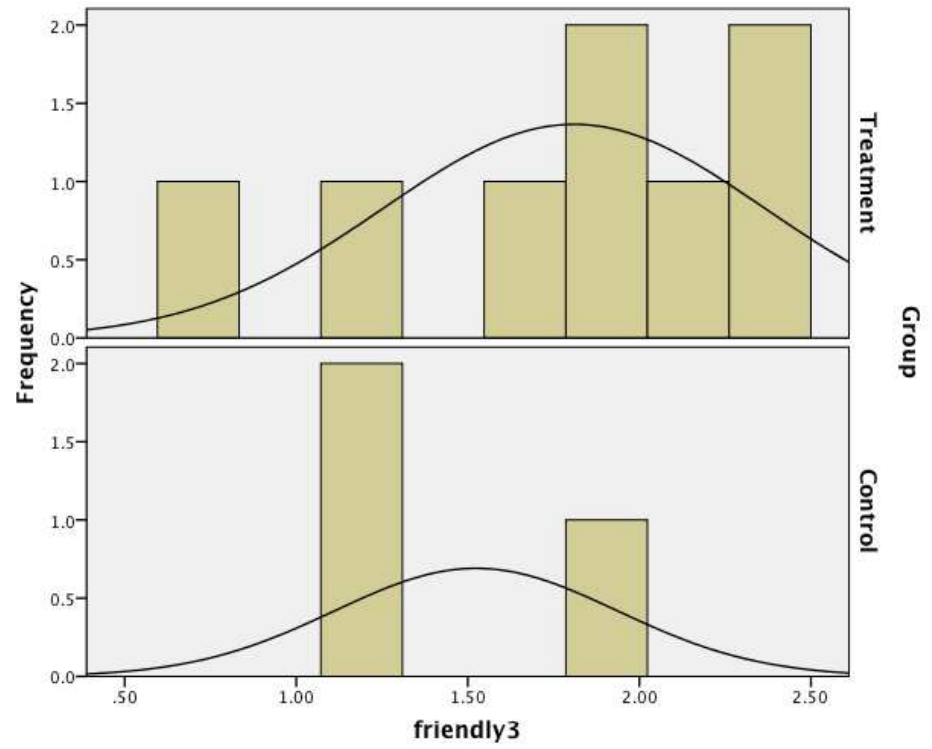


Figure A4d8.iii: friendly3

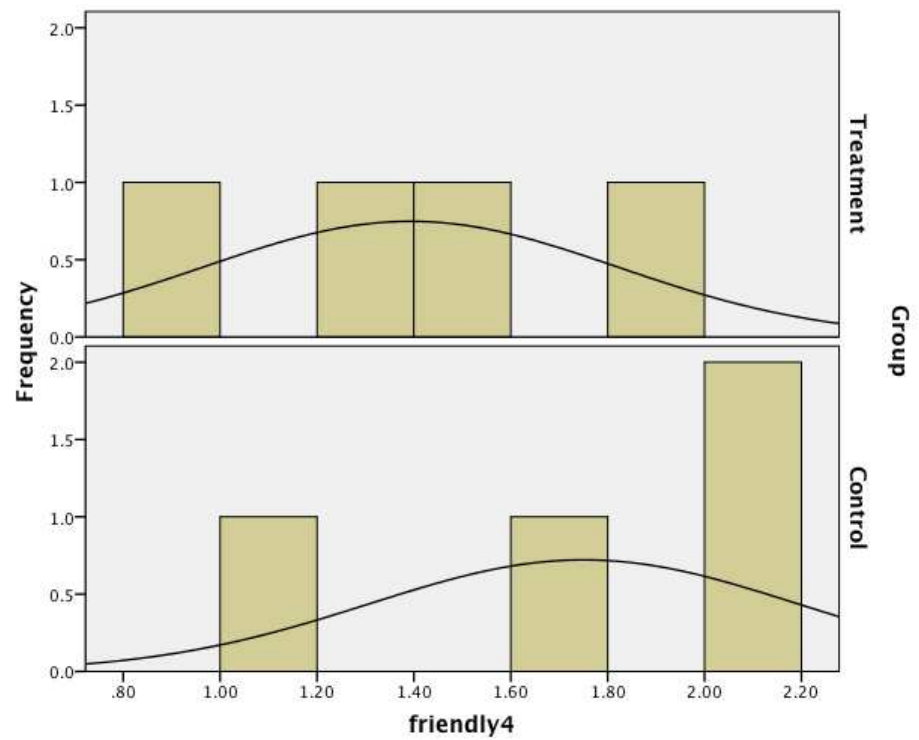


Figure A4d8.iv: friendly4

4d9: Sociable

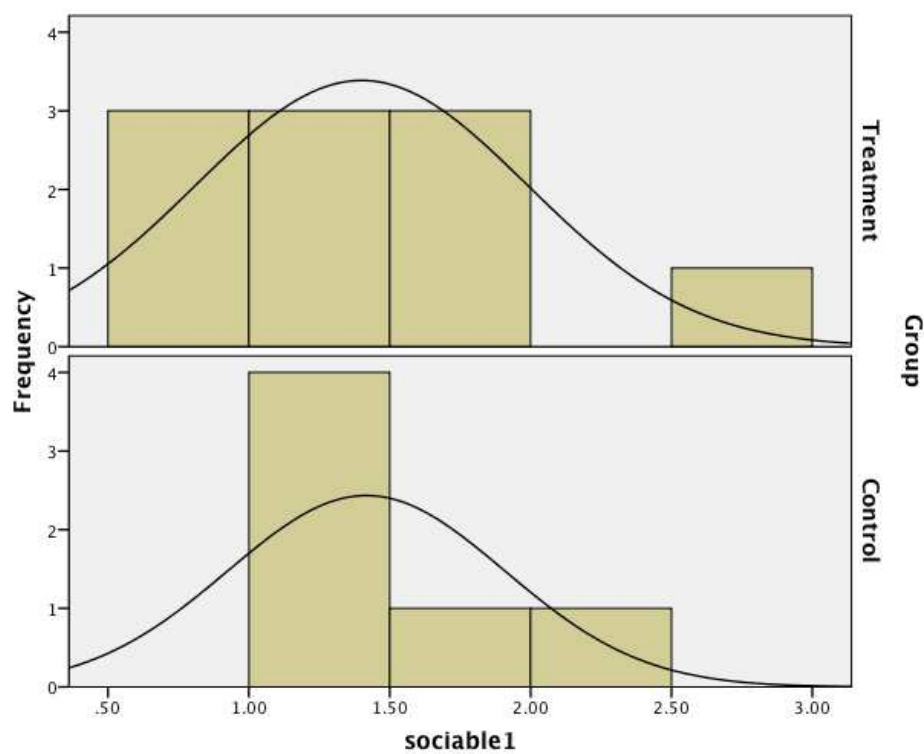


Figure A4d9.i: sociable1

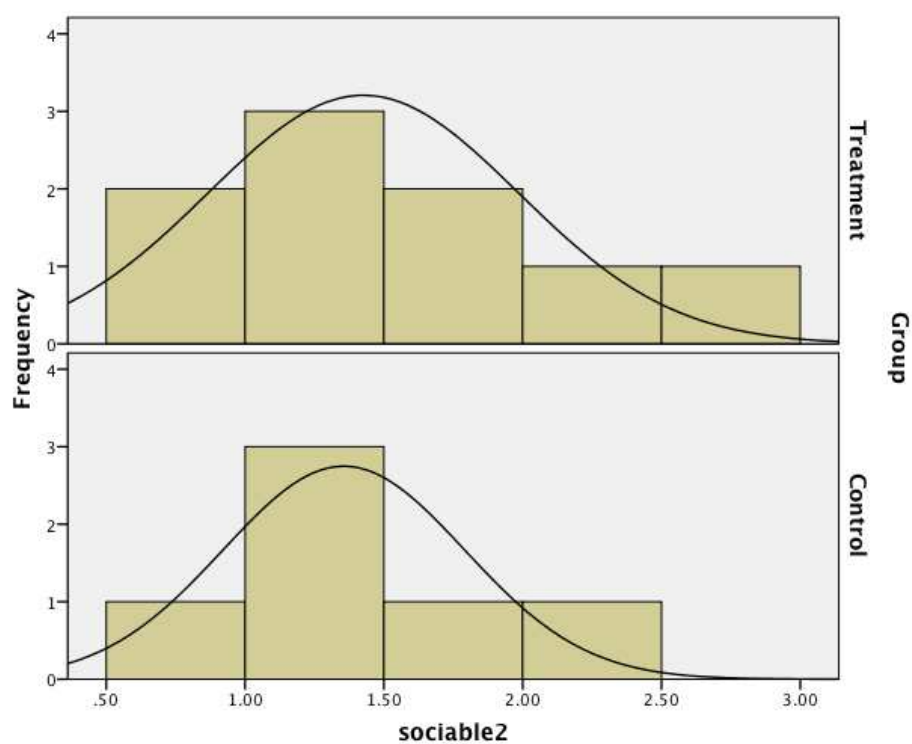


Figure A4d9.i: sociable2

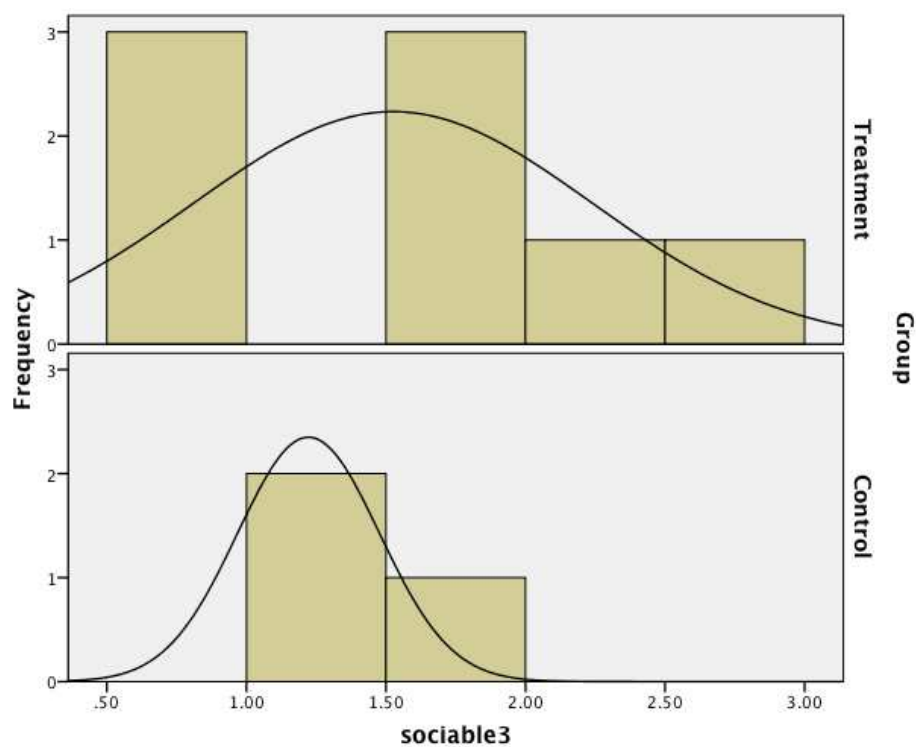


Figure A4d9.iii: sociable3

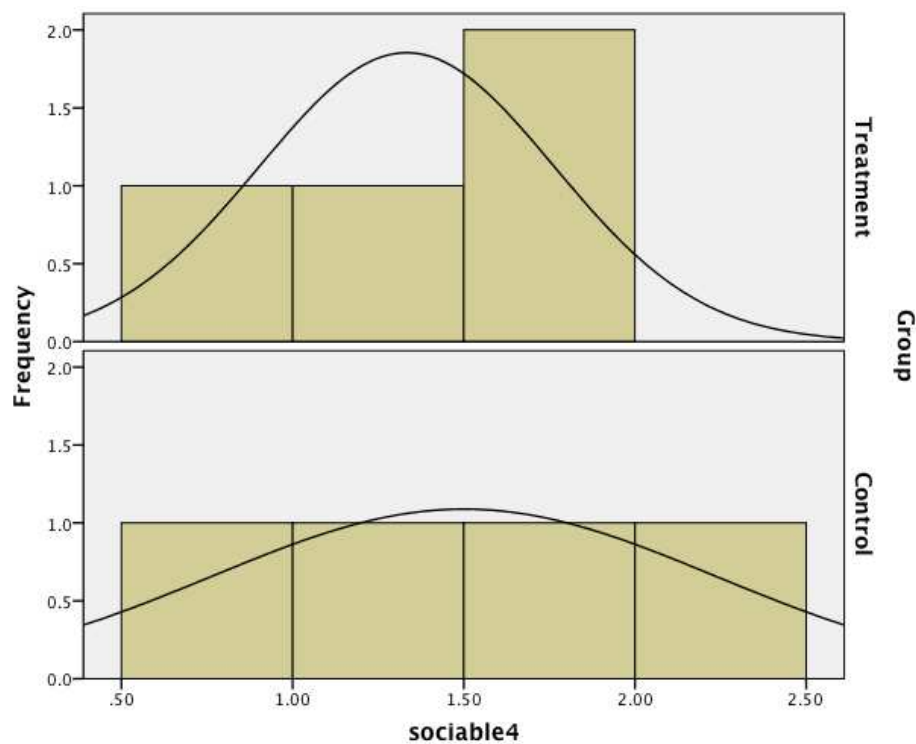


Figure A4d9.iv: sociable4

Appendix 4e: Treatment effect across time and by groups (secondary measures) Hypothesis 1

4e1: MDI domain disengagement at time points 1, 2 and 3 by groups

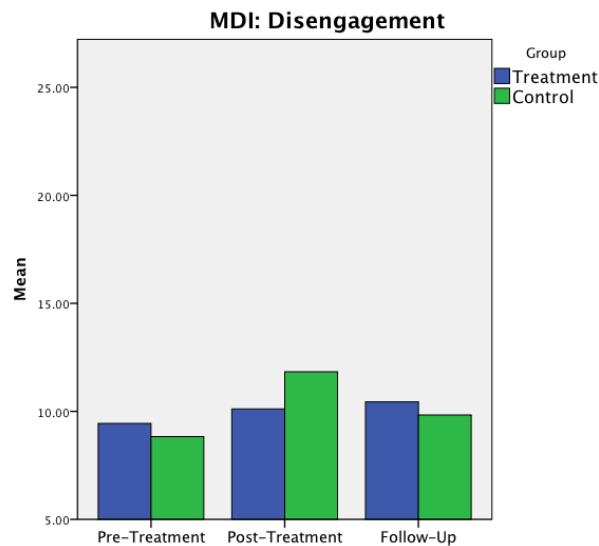


Figure A4e1: Domain disengagement – treatment and control across time.

4e2: CIRCLE domains at time points 1, 2 and 3 by Groups

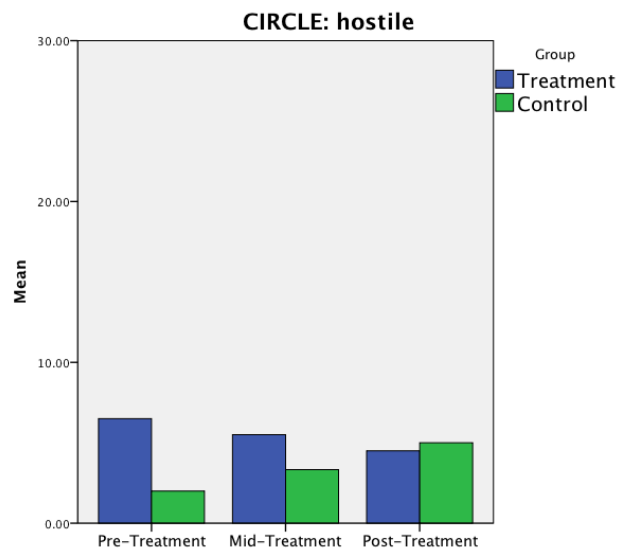


Figure A4e2.i: Domain hostile – treatment and control across time.

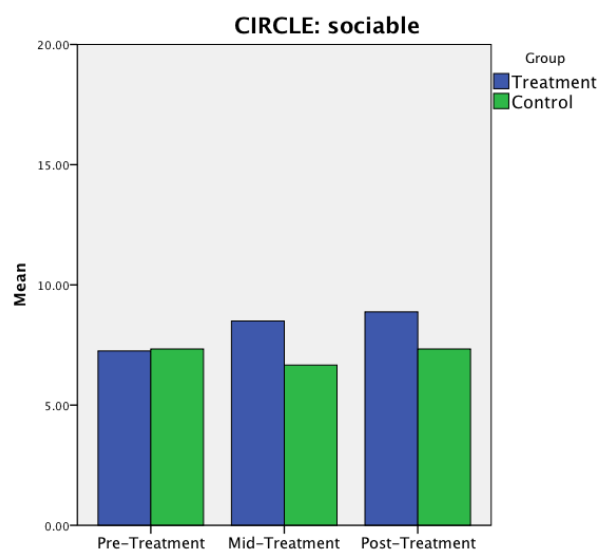


Figure A4e2.ii: Domain sociable -- treatment and control across time.

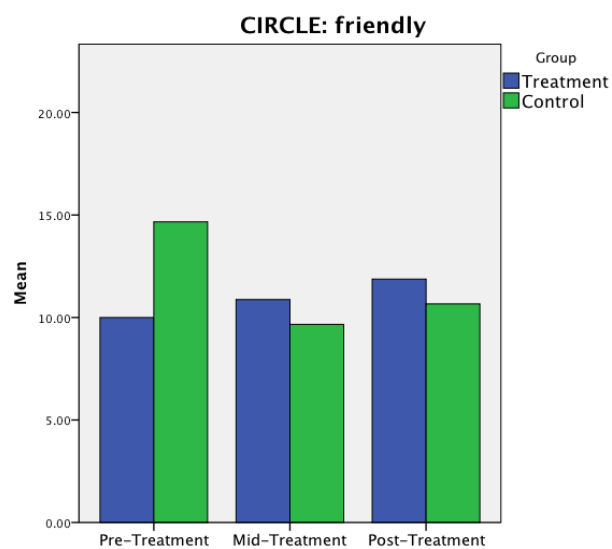


Figure A4e2.iii: Domain friendly -- treatment and control across time.

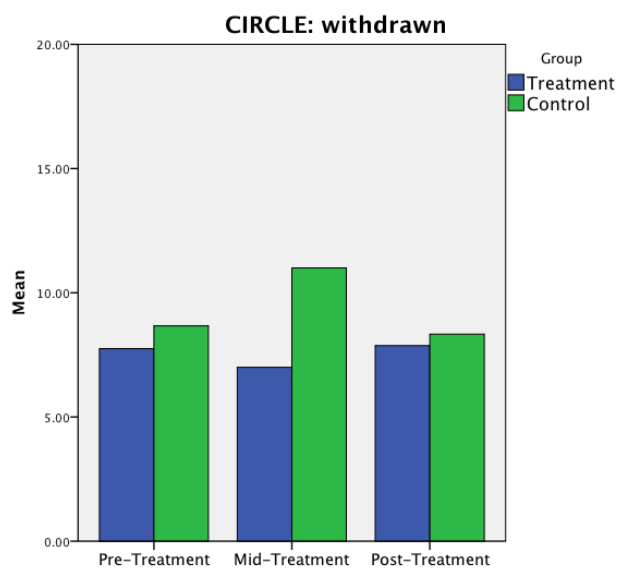


Figure A4e2.iv: Domain withdrawn -- treatment and control across time.

Appendix 4f: Treatment effect across time and by groups (secondary measures) Hypothesis 2

4f1: BES domains at time points 1, 2 and 3 by Groups

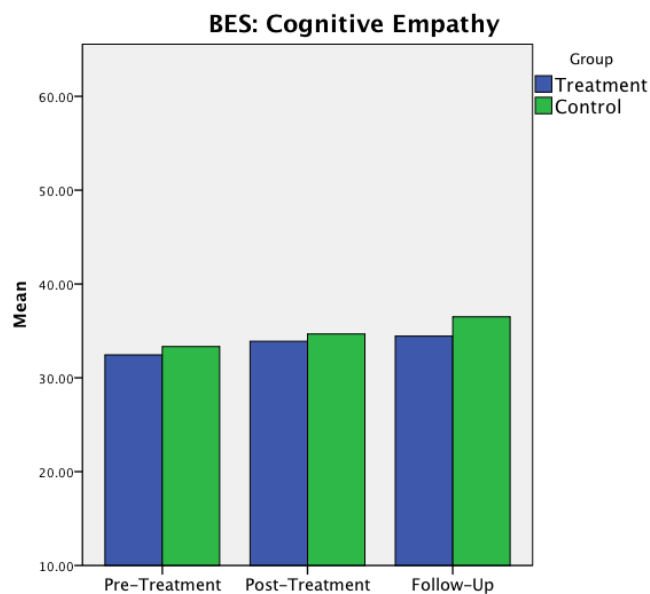


Figure A4f1.i: Cognitive empathy -- treatment and control across time.

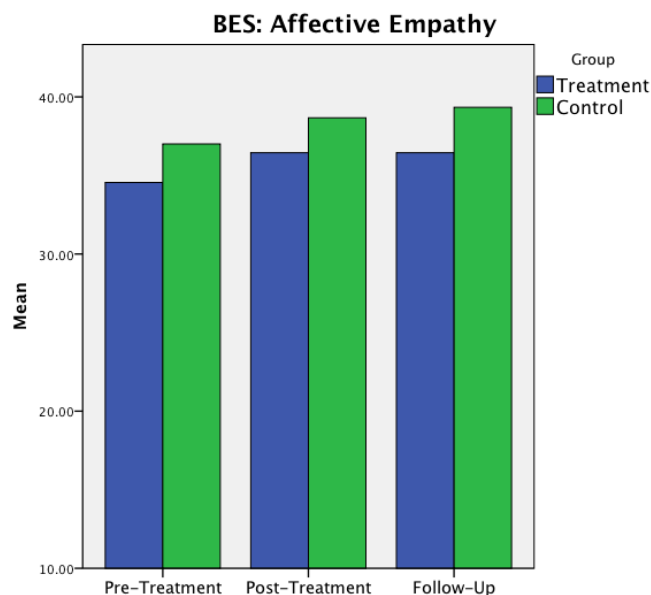


Figure A4f1.ii: Cognitive empathy -- treatment and control across time.

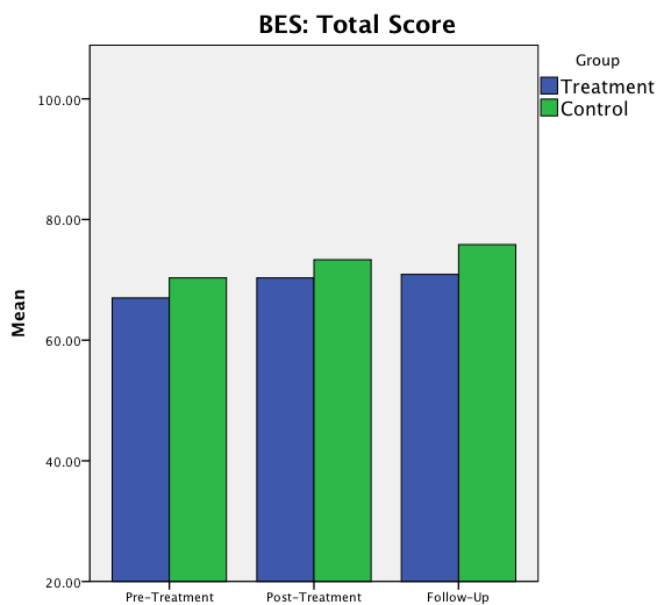


Figure A4f1.iii: total score – cognitive and affective empathy -- treatment and control across time
(score range: 20 – 100)

4f2: MDI domains at time points 1, 2 and 3 respectively by Groups

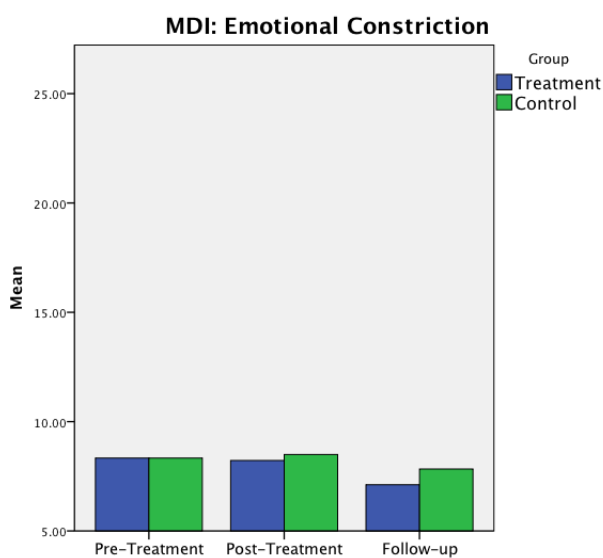


Figure a4f2.i: Emotional constriction, - treatment and control across time

Appendix 5: Feedback

Appendix 5a: MT Patient Satisfaction Questionnaire

Beeley & Compton (2010) from Odell-Miller & Hughes. An investigation into the effectiveness of the arts therapies for adults with continuing mental health problems. *Psychology Research* (2006) 16(1):122-139

Question1: What was it that made the therapy helpful?

Looking back at what I had done (meaning life events) made it useful and helpful.
Learning new skills and working with different people.

Good stuff.

Being able to express with others, and ideas of the musical nature being able to share in this experience to interact with others ideas of a musical nature. Being able to share in this experience. To interact with others in ways that are helpful and unusual.

The atmosphere was positive, the energy was relaxing.

The therapy was enjoyable I was able to relax and looked forward to each session.

The opportunity to talk to a professional. Simply communicating with another person.

Easy approachable manner and easy chat-able staff to make me feel calm and comfortable.

An excellent facilitator/ therapist.

It increase my empathy skills and made me better a listening.

It encouraged teamwork and making 'room' for each other.

Learning new skills and working with different people.

Question 2: How do you think that this therapy has helped you to change?

It made me stop and think about my strong points and weak points and gave me an understanding of what I need to work on.

It made me more curious and gave me greater insight.

I can just relax when I think of music therapy. I feel as if the whole group was based on principles that were completely non-judgemental.

It helps me to keep time beats within myself, to talk, have conversation and relax.

The experience itself gave me an insight into the way others and myself included share ideas and I feel this was in enlightening.

Able to express myself more creatively.

It gave me more feelings.

Working closely with others in a similar predicament.

I am a better listener.

It reminded me to keep in touch with myself and try to connect with Others.

Appendix 5b: Client Satisfaction Questionnaire:

Attkisson and Greenfield PSQ-8UK English (1994)

N=7

1. How would you rate the quality of the service you received?

X4Excellent

X3 Good

2. Did you get the kind of service you wanted?

X2 Yes definitely

X3Yes generally

X1 No definitely not

'X1'I don't know what service I wanted'

3. To what extent has our service met your needs?

X2 Almost all of my needs have been met

X1Most of my needs have been met

X1 only a few of my needs have been met

X2 None of my needs have been met

X1 'I dont know what my needs are'

4. If a friend were in need of similar help, would you recommend our service to him or her?

2xYes definitely

4xYes I think so

5. How satisfied are you with the amount of help you received?

3xVery Satisfied

2xMostly Satisfied

1xQuite satisfied

6. Have the services you received helped you to deal more effectively with your problems?

X2 Yes they helped a great deal

X4 Yes they helped somewhat

X1 No they really didn't help

7. In an overall sense, how satisfied are you with the service you received?

X4 Very Satisfied

X3 Mostly satisfied

8. If you were to seek help, would you come back to our service?

X2 Yes definitely

X4 Yes I think so

X1 No I don't think so

8. How satisfied are you with the information provided about the services and treatment available to you?

X5 mostly satisfied

X2 mildly dissatisfied

9. Are you satisfied with the range of treatment offered to you?

X7 Mostly satisfied

10. Do you feel that you had enough choice about your treatment

Very satisfied,

5X Mostly satisfied

2X Mildly dissatisfied

11. Which treatment do you prefer for stress, anxiety, depression?

4X Both taking therapy and medication

3X Medication

Talking therapy alone

12. Feedback

The smoking ban and fitness ethic has meant that non-medicinal approach can be workable and effective. Non-medicinal has some way to go but could be really effective.

Fantastic facilitation.

Sessions could be longer.e.g. All afternoon, given time to play more, to discuss more issues

More instruments to play with and technology

Its fine how it is. The formula works

Appendix 5c: IPA Arts Therapies Questionnaire

A)				
<i>Questions</i>	Triangulation to PROQ2 and BES	<i>Emergent themes</i>	<i>Original Transcript</i>	<i>Exploratory Themes</i>
1. What was it that made the therapy helpful?		Reflecting is helpful	“Looking back at what I had done made it useful and helpful.”	Self –reflection was possible
		Learning with different people	“Learning new skills and working with different people.”	Learning new skills through making music together extends the zone of proximal development (ZPD)
			“Good stuff.”	Postive experience
		Sharing the expression of emotions=not alone	“Being able to express with others.”	Emotional expression involved relating to others
		Unusual and helpful ways of being with others	“Being able to share (x2) musical ideas with others and to interact (x2) in music.” “To interact with others in ways that are helpful and unusual.”	Sharing and interacting with others in music was helpful and unusual. Interacting /relating with others was experienced as positive
		Motivated to come back by energy generated, feeling relaxed	“The atmosphere was positive. The energy was relaxing .” “The therapy was enjoyable, I was able to relax and look forward to the next session.”	Energy generated was positive (rather than stressful?
		Communicating was helpful	“Opportunity to talk to a professional.” “Simply communicating with another person.”	Communicating with words became simple, because therapists were ‘approachable’

			“Easy, approachable manner.” “Easy, chat-able staff, make me feel calm and comfortable.”	Easyx2 interpersonal style enables calm and comfort
			“Excellent facilitator therapist.”	
		Developing listening skills had a pay off- it helped empathy	“Increased my empathy skills, made me better at listening.”	Being able to listen increased empathy
		Being with others in the group helped them learn to give others space.	“Encouraged team-work and making room for each other.”	Working together and giving each other space+ exploring closeness and distance
			“Learning new skills, working with different people.”	ZPD
2. How do you think that this therapy has helped you to change?		Self-reflection possible on personal Target problem and Target Aim, because he could <u>stop</u> and think.	“Made me <u>stop</u> and think about my strong points and weak points, and gave me understanding of what I need to work on.”	Stopping encouraged thinking, helped to define objectives or goals?
		Curiosity linked to insight	“Made me more curious and gave me greater insight.”	Extended curiosity (ZPD)
		He was able to relax and have a positive experience in which he felt accepted. (Improved self esteem?)	“I can just <u>relax</u> when I think of music therapy. I feel as if the whole group was based on principles that were completely non-judgemental.”	
		He could <u>feel</u> Rhythm within himself & this enabled him to relax enough to connect to others	“It helps me to keep time-beats within my self, to talk, have conversation <u>and relax.</u> ”	Linking rhythm to embodied sense of self, relaxing and opening up to talk
		Experiencing this intervention helped him to understand others	“The experience itself gave me an insight into the way others, and myself	More able to think about himself and others, then to share

		and himself and to have insights	included, share ideas, and I feel this was enlightening.”	
		He could be more creatively expressive	“Able to express myself more creatively.”	
		Her could recognize his feelings	“It gave me more feelings.”	Emotional recognition developed
		Sharing their ‘predicament’ may indicate greater acknowledgment of the offence	“Working closely with others in a similar predicament.”	Acknowledgement of their ‘incarcerated ‘predicament’
		He could listen to others better	“I am a better listener.”	
		He could understand his own needs and connect to others	“It reminded me to keep in touch with myself and to try to connect with others.”	Relating to others having related to himself

Appendix 6: Raw interview transcripts

Appendix 6a: First semi-structured interview with Victoria Sleight

Date: 11th August 2011

SC: Victoria, the first question in the interview schedule there are four general questions and the first question is about the treatment manual, can you describe generally what it was like for you to follow the manual in delivering music therapy?

VS: I think the manual was quite useful in terms of helping me with the structure, what I was going to do, both through the assessment and through the very first sessions. It gave quite a lot of useful pointers in terms of what we normally think about, but actually made me focus even more, the assessment part of the study was really interesting and I think for me having that protocol, having that manual as a reference and using the psycho-therapy helped me hone my skills. It was tiring because you are looking for a lot and you were burning a lot, but as a professional person it made me feel quite empowered actually and I think for the patients as well that helped, because we knew exactly where we were going and knew what we were going to achieve in that session and that we have that time and those boundaries around it and formulating a target was really, really useful, because that was the thing I had in mind going into the first session with each patient and then to be able to pool those target problems together helped me think, well if this comes in a group I can use that to begin to help them think together and see what is commonised things there are. I think the very first session we thought a lot about the instruments and what it meant to have lessons instruments in the room.

SC: Let me stop you there. What we want generally speaking, we'll come to those specifics of observe and describe and experiment. So, we've looked at how you describing generally what it was like to follow the manual and you're saying, if I understand it, that it gave it structure, some useful pointers and more focus, and that the assessment was interesting because you had a protocol to follow.

VS: Yes.

SC: And you could refer to the manual and the psychotherapy file which was honing your assessment skills, is that correct?

VS: That's right, yes.

SC: Okay. So at this very early stage of treatment you've just done your first group session, I think you've also clarified some points there about, how did you feel, not generally, but how did you feel personally about following the manual in a nutshell?

VS: I liked it, it helped me and I think it gave me a vision of where the treatment was going to go and how it would be a nice rounded piece of really useful work.

SC: Great. How would you describe the main differences between following the manual and your usual way of delivering music therapy? I know that you've done

some work in the pilot one, so it may not be that different I don't know, I don't want to suggest that, but..

VS: I don't think it was hugely different to what I normally do, its maybe just helped me move through a bit faster and not fluff around, I think that's the best way to describe it.

SC: So you weren't fluffing about, do you think it was more intense?

VS: Yes, but in a good way. I think it was clearer, it provided clarity, but I was still able to use those psychodynamic skills to help me to facilitate the sessions, they didn't feel that they were taken away from me.

SC: Fantastic. Wonderful. Can you describe in your own words how you've modified your techniques for this group? I think that's something we've been thinking about over these weeks, so..

VS: I think, I'm a lot more mindful of the input I'm giving to the group, I think, in terms of music stance and I'm a bit more directed verbally, I was able to stop people if I felt they were going on too much or I was able to be a bit more directive musically, but still allow that stage for them to experience and grow to themselves.

SC: Okay, that's. Let me just see if we can take that a tiny bit further when you're talking about how you modified your techniques, you said you were more directive and that you were able to feel that you could bring the music to a close?

VS: Yes, if it was getting a bit rowdy or bit disconnected perhaps, where they were off in their own word, if I wasn't able to bring them back using grounding techniques then I was able to stop the music. I was able to stop it at one point because it felt like one person was just going on for the sake of it and it was becoming almost destructive in its nature and whereas before I think I would have let that happen..

SC: I wonder how that was received?

VS: It was received okay, I think there was a bit of a sense of relief and I think for the person in question it was contained because they didn't know how to finish, they didn't know how to stop.

SC: Well it is only session one isn't it?

VS: Yes.

SC: So that's very useful to know. Can you say anymore generally about how you have modified your techniques from the point of view of running a group, this your first G-CAMT group on your own?

VS: I think I was very aware of being on my own, but in a way I felt more in control because although it's really helpful to have a co-therapist sometimes it can be quite hindering..

SC: Yes

- VS: There's that relationship to think about as well, and I think I was really trying to watch everybody in that room as well and observe what was happening and I think sometimes when you've got somebody else in the space with you, you concentrate on them people and not others and perhaps you split by default, so it's a bit more equal actually, a bit more balanced and you can move it at your own pace as well.
- SC: Would you say that you felt that it was your group?
- VS: Yeh, it did actually, yeh.
- SC: Excellent. Even on session one, so when I say that I mean, did you feel you had sufficient clinical autonomy within using the treatment manual?
- VS: Yes, I feel that the manual was more of a guide, a way to help you focus when you work, so that you are still able to be a music therapist in there and use your way.
- SC: Do you want to say anything about the music that happened?
- VS: I think, at this point the music was at times really connected and at other times quite dis-connected, as we were finding our way together as a group, the sound print thing was really helpful actually in terms of the patient gravitating towards an instrument that they could feel safe really and although I don't think all of them have found one that is right for them yet, there is certainly one patient who found that quite quickly and it was clear because he kept going back to it.
- SC: And what instrument was that?
- VS: It was small djembe drum and he physically and as well as musically you could see he was comfortable with that.
- SC: How did you introduce the idea of the sound print?
- VS: We were talking about how different instruments might bring out different things, supposing it was though the mindful exercise, what does it feel like, what does it look like, why did you choose that instrument, that how we got to the sound print.
- SC: That sounds like a good place to go onto the more specific questions, doesn't it, on the schedule. Here we are after session 1, first we're looking at your observation of patient experiences though this tape doesn't go outside the secure area, but just use first names of patients if you would like to, any of them, and take your time to think about each in turn, about how could patients observe, describe and experiment with the instruments themselves during this session one, if yes, how did they do this, if no, what did they do? So we've got 5 patients haven't we?
- VS: I think it varies from each patient to each patient and their individuality really and some of them found it very easy if for example, after he chose the djembe drum, he found it very easy to think about the drum, what it meant to him, how it felt, how it sat on his knee..

SC: Oh, lovely.

VS: You know the sound that it made and how that sound came through the music and what it did for him when he played, he was able to describe that really easily and..

SC: In what way, what were his adjectives for how it felt to have the djembe sitting on his knee?

VS: He said it felt really nice being in contact with something quite organic..

SC: Was that his word?

VS: I don't think he used that word, rough, the rough skin of the thing and he liked the ropes on the side, he liked the feeling of that as he touched it and he held it under his arm and he turned it upside down and looked through the sound hole and smelt the linseed oil and I think for him because he is blood Nigerian descent he was quite interested into where it had come from, it was quite important for him that it was an African drum. I think he was probably the most vocal about that..

SC: So was there a cultural aspect to it for him?

VS: I think so and that was picked up by another patient actually that there was lots of instruments from different cultures and when we did the first improvisation and chose the instruments they were all very interested in where do they come from and they spent time because we'd got the drum set away from the circle and they went to chose their instruments they spent time listening to the sound and finding the sound they wanted or was it to do with the size, or the colour, was that it that physical it could sit on their lap or they had to hold it on the floor and how did they make that sound different, it was quite nice really.

SC: So can you just tell me how you set the room, it sounds like you've got the drums outside the circle of chairs and its sounding as though the patients have a good degree of choice as to how to wander about.

VS: The way the room was set up was to have a bank of drums outside because we felt that it means that the patients have to physically move and it brings energy to the space and also means that they don't just chose what's sat next to them.

SC: Brilliant. Fantastic.

VS: And then in the space we decided to put the main ??? stand bar on the table as a focal point because that's going to be used right through the manualised treatment. We had two more sounding bars out, the higher sounding bowl with the green pegs on a small table again outside of the circle and the medium sounding bowl we sat just on the edge of the circle and then within the circle we had 3 matlaphone and 2 xylophone but we just kept them diatonic, we took away the other part.

SC: Fantastic.

- VS: And it was quite an airy circle it felt that it was important that there was space and at the other end of the room, we had a small table just for the selection of smaller instruments, Tibetan chimes, Para chimes, which we put there again so that they had to move but again so they could think about, well what does that represent, the smaller instrument and when is it appropriate to choose them, and just, I think really to make the space feel quite open so that we could explore together what we wanted as a group.
- SC: So you've got to the point of exploring already partly it sounds to me by how you've set the room, so that patients have to physically get up to go to explore.
- VS: Yeh.
- SC: As I understand it you're saying that, can I just ask, did they come in and sit down in the first place or what happened at the beginning?
- VS: Yeh, they all came in and they all sat, well I've one man using a wheelchair..
- SC: Right.
- VS: So I left a space for him, but they all sat on one side of the room and filled the chairs straight away and there were 2 chairs left.
- SC: Sorry about that interruption there.. Yes, you said they all sat down and of course its Oscar who's in a wheelchair isn't it.
- VS: It is. Oh yeh, one patient was late coming to the session which was something we just had deal with, but actually he didn't really choose his chair he had to have the chair that was left.
- SC: Right. That's interesting from a point of view of how chose developed during the session.
- VS: It didn't seem to impair him of his chose at all, he was able to still get up and choose the drums, let me think, he was half an hour late coming so at the point because it was the first session.
- SC: Of course.
- VS: We'd just done the introductions and thinking of housekeeping and those kind of things and looked at our folders, we were just about to start the first improvisation.
- SC: Okay.
- VS: But there was still some drums left because the first improvisation was drumming.
- SC: So, can you tell me a bit about how you've set up folders for each of the patients?

- VS: Yeh, within each folder, each patient has a timetable showing the different sections of the treatment and clearly with the dates on and then the break, so that's on the first page. The on the second page is their target problems, what we'd agreed either with them in the session or afterwards and then they've got a copy of their psychotherapy file in there as well and what I ask for them to do is to have a look at their target problem and if it didn't sit with them to think about how they would like to change it, if they wanted to change it that was fine, we could think about that later on in the group, and I also said to them you have got your psychotherapy file in there, we will be referring to that in the group, but it would be really helpful if you had a look through it in your own time and we spoke about how, well I said to them, its entirely up to you what you share within the group, I'm not going to share anybody's target problems or what you said to me within the group say, I might draw on themes and then its up to you, if you want to specifically articulate what you said.
- SC: So, just to clarify, you're not divulging anything that each of them have said individually to you in their one to one clinical assessment, which was a clinical assessment to prepare them for coming to the group.
- VS: Yeh, that's right yeh.
- SC: Were there any patients who actually couldn't observe, describe and experiment with instruments, if so, what did they do?
- VS: I think the one person that sticks out for me is David, although David is a lot further on in his treatment and due for discharge to an MSU he really struggled with connecting emotionally and thinking about what could he see just, especially the sound bowl, he kept saying it was just like a guitar, he couldn't go on to think well what does the pegs do, what does it feel like on the strings, what are the sounds you're making.
- SC: So do you think there's a flooding of emotions there, it sounds to me as if there, we've got to think about the different, what does it look like, what does it sound like, what does it feel like, these are all different senses, so with David, what you've said is that he didn't seem to be able to connect with what it looked like, so could one do you think over the weeks of this first four sessions help him to focus on one of his senses through he which he maybe to use the instruments?
- VS: I think so, I think for him what he does is he tries to connect to something familiar that is knowledgeable, so for example he'll say it looks like something I've seen on the telly or it sounds like a piece of music I've heard before, it doesn't feel like he's describing what is actually in the here and now, the quality of what he's saying is almost lifted from something else.
- SC: Right..
- VS: You know, it's as if it's, not connected up, that's the only way I can describe it.
- SC: So it there something here about how he's defending against using the instruments?

- VS: I think so, I think using the instruments takes him to a place that he's not that comfortable with, verbally he's very comfortable.
- SC: Thank you. Victoria, the last question is about your own experience and the what was the nature of your experience as the therapist, this might have to do with counter-transference or transferences or reciprocal roles that you've may have seen and acted in the music, anything really that comes to mind. When you are asking patients to observe, describe and explore, those three things?
- VS: I think it changed as the session went along, initially it was quite easy because it was quite a nice thing to be able to focus on and then as we got into the music, you know, further on in the session, it felt more difficult to come back to that, it felt like because we'd played there was lots of other things we wanted to talk about and it felt ..
- SC: You say, "it felt", how did you feel?
- VS: Yeh.
- SC: So you're talking about the group process, you sound like you're really in there it sounds to me, so what did you, what was the nature of your experience, for instance, for example, this was your first group, we've thought about it, always starting a group one feels anxious, will they turn up, will everything be okay, and we thought about your anxieties in supervision before we started, so the nature of your experience as the therapist in, having these patients in the room with you for the first time, all sitting down in a circle and introducing them and inviting them to observe what they see, to describe what they see or feel and to walk about to explore and to make choices, because you're important, what was it like for you to have that there?
- VS: I think I did feel anxious at first, because that's the first time we've all been together as a group, and I also felt quite protective.
- SC: Of what, yourself? Of them? Or of the space?
- VS: I think of them, I think of us as a group, I felt like I needed to hold that together, my role was very much to keep everything safe and I felt quite in control of what I was saying, I had a plan in my head that I'd played to myself prior to going into the group, so I'd got that structure and I felt quite empowered actually towards the end of the session when we started to write some things down, I felt okay actually, in my head before I thought I'm not going to be able to do this.
- SC: Are you talking about actually using visual aides and diagrammatic work.
- VS: It wasn't really diagrammatic work as such, but we wrote down some words that were coming into our minds after the improvisation.
- SC: Fantastic, that's brilliant.
- VS: And it was really interesting to see what words were coming from certain people and I actually said would it be okay if I wrote something on the diagram, because

there was a point when I thought oh no, its not okay, and then I thought no it is okay because I'm part of the group.

SC: And you're facilitating the group.

VS: Yeh.

SC: And they're there to learn from you non-didactically but by your example learning from you being the more experience other, so that they can in the first place feel led if they need to be led by copying for instance and imitating.

VS: Yeh, there was a certain patient that required quite a lot of validation, he kept looking for that validation and I felt able to give it to him but interestingly what was different in his assessment I felt that I had to give it all the time, in the group I didn't feel that, I felt that I could share that validation with each of them and there was more of a balance.

SC: So to finish, would you be able to share with us, this interview, the words that they finished with, is that useful thing to do?

VS: Yes.

SC: Did it add meaning as it were?

VS: Yeh, it did have meaning to each of them individually, that we all passed the sounding bowl around they all played something short and I had to be quite direct with them about that, but for example Mick's words were that he felt calm and it was like a waterfall and I think that was pertinent to the way he played actually.

SC: So it was congruent?

VS: Yeh. ?? couldn't actually say anything he found that really difficult and then as he was playing he said 'oh it rythmatical – his word'

SC: So he made up a word.

VS: He made up a word, but the way he played was very interesting, using the outside of the string and then down the middle, and it was very rhythmic and mathematical too.

SC: So that's quite interesting. Rythmatical – so you said he used rhythm?

VS: Around the bowl like that, yeh and then through the middle, quite interesting.

SC: That's a sacred image.

VS: Oh yeh.

SC: Yeh and the sounding board were built on the sacred geometry.

VS: Oh interesting.

SC: So he's just done the PHI,

VS: That was it.

SC: How extraordinary.

VS: How

SC: So that the ancient symbol.

VS: Right.

SC: So, he just went round and then down.

VS: Yeh, that's what he did, yeh.

SC: Extraordinary from an unconscious point of view.

VS: Yeh, yeh.

SC: Finally, because we've just got a couple of minutes left.

VS: David just said guitar. I found that really hard his playing was reflective of how hard he found it, then, what did Ben play? I'll come back to Ben. Oscar said creative.

SC: Wow, and what was your word.

VS: Together, cos it felt really together at that point. What was Ben's word – it was something quite abstract, that I didn't feel reflected anything at all really, something like fairground or something like that.

SC: Well perhaps it was fun. But it does sound like you're going to look after David doesn't it.

VS: yeh, yeh.

CS: Victoria, thank you very much for this interview and so we completing that it's taken us half an hour and that's really wonderful information, thank you.

Appendix 6b: First semi-structured interview with Claire Newman after the G-Cant Group

11th August 2011

SC: Claire thank you very much for being in this study and we're going to start with some quite general questions. The first one is really about your general experience of delivering manualised forensic music therapy in this model, so I know that you've spent some looking at the treatment manual, preparing for this start, can you describe generally what it was like for you to follow the manual in delivering the music therapy group today?

CN: I think it's been good to have some focus, it's given me more focus that I might usually have in the first session. I think because the thinking of the words of the describe and explore and experiment and those kinds of things, it does give me a focus and it helps me to direct the group in terms of what they might get from the music and how they might describe it and actually what they need to look for as well.

SC: Can you give me an example perhaps from today's session?

CN: To be honest, I don't know that at the beginning I said anything about observe, explore,

SC: Describe.

CN: I didn't use those words.

SC: Okay.

CN: It came up probably using the sounding bowls that people were kind of offering their thoughts as we passed the bowl around, somebody might play and then, it wasn't always that person that responded but maybe someone else in the group said something about how it's sounded about the resonance, they were surprised how resonant the bowl was for such a shallow bowl it kind of made such a big sound.

SC: So that's a subjective quality isn't it of resonance, it's an observation of sound.

CN: Yeh.

SC: That particular sense.

CN: Yeh, it was and as well the feel, and how it felt, the kind of texture underneath and how it's different from the smooth bowl on the top.

SC: Who did that? Who said that then?

CN: Sean Colgan, he was talking a lot about the actual feel. Carl, he'd never played it before, because of his assessment it just got omitted.

- SC: Right.
- CN: Yeh, for whatever reason.
- SC: So how did he get on?
- CN: He kind of have a little rattled with it as they came in and sat down. So it was playing it before we really started properly in the group, so when it came round to him, I tried to make sure that no one felt that they had to play, but that it was, they were naturally just passing it round and he played, and played it quite gently and it just seemed to make him at ease, he'd come into the room and he talked about how he'd had a difficult week and he was feeling quite pissed off and he brought in his target problem which about how he can express that kind of thing in the group, he said that straight away.
- SC: So lets just pause a minute, and think about the question then, so this patient we're going into therapy process here, we're thinking what was it like for you to follow the manual. What you've said so far, is you didn't use the words specifically observe, describe, experiment but that the patients naturally took to the instrument that was central and offered their thoughts and observations about what it sounded like and what it felt like, yeh?
- CN: Mmm.
- SC: Now what you've said that with Carl he immediately offered his target problems, so that's different is it not.
- CN: Mmm.
- SC: That is something that is in the manual isn't it?
- CN: Yep.
- SC: Everyone needs a target problem, yeh?
- CN: Yeh, and at that point it wasn't I'd not really said anything about whether they'd be shared in the group, he was quite open about sharing that, so..
- SC: So, what was that like for everyone in the room?
- CN: I felt quite relieved that he'd been able to do it, cos I wondered if him being able to talk like that might encourage other people if they felt brave enough to share something of that as well, rather than I suppose before the group wondering, is it going to be something that each keeps secret, its going to be their little secret or is it something we're going to be able to work with more openly.
- SC: And could you work with the target problem openly? Could the group work and embrace what it was that Carl was talking about?
- CN: Yeh, Jacob immediately kind of laughed as if like knowingly, as if to say 'yeh, I know what you mean'.

- SC: Can you tell me what that target problem was?
- CN: It was about expressing negative feelings in the group.
- SC: Okay, great. Did Carl express any negative feelings during the session?
- CN: I think in the music he certainly allowed himself to really let go, I think probably cathartic playing from him. And I felt that it triggered something in other people actually, it didn't feel threatening in the sense that people were feeling unsafe by it, it felt like they were identifying with it. It felt quite important.
- SC: And which improvisation was that, was that the loud drumming one?
- CN: We did two with the drums and they were both fairly upbeat and became quite loud, they both had similar qualities to be honest, but for each one person volunteered to start the music and then they kind of built it up, so that they didn't all come in together.
- SC: Right, so that was structure then?
- CN: Yeh. So there was a slightly different quality I think when, cos Jacob provided the second beat which was more complex, he's a musician anyway, and I think he wanted to bring something more complicated and show his skills, so he began and again the group came in one at a time. I can't think...
- SC: Okay, that's great. Okay, so in a way the manuals inviting you to use structures to create the improvisation and contain them. Is what you've just told me an example of that do you think?
- CN: I think so. I was aware as well about time and not just something we just thought about but not just kind of just letting it drift on and I gave time boundaries before we began so that it wouldn't just go on and that we would be able to have to have a chance to kind of end it and be aware that we were going to end at a certain point.
- SC: Fantastic.
- CN: So that worked as well.
- SC: So that's one of your ideas isn't it, so what was your time boundary for improvising?
- CN: Well I think we had the first one worked out to be about 7 minutes, we kind of started and then finished on a number on the clock so, we just kept going and then I think people were aware they were watching as well to make sure that they didn't go beyond it.
- SC: What a brilliant idea. Thank you for that. So it was jointly created music from a point of view that everyone was signed up and agreed would, sounds like, did everyone agree on the time boundary for improvising?

- CN: They were happy, well they were happy with it, yeh.
- SC: Wonderful. Okay so that's certainly is different than..
- CN: Mmm.
- SC: So how did you feel at this stage of treatment honestly of following the manual – session 1 – and you're gunna have 3 more sessions of doing observe, describing, experiment, yeh?
- CN: Yeh.
- SC: How did you feel personally at this stage in following the manual and actually doing it for real?
- CN: I didn't feel that confident, I suppose cos I not worked in that way before. I was wondering how it might be different and because there were so limited amount of instruments I suppose I wondered if we might, if people might get frustrated or want to use different things, or whether actually that might be more about me wanting to use or have more things.
- SC: So what did happen?
- CN: Actually, we could have probably done another hour, it really felt like that we reached a point by the end of the session were I wanted us to think about sound print.
- SC: Yeh.
- CN: But there wasn't really enough time, so I just sort of introduced the idea and said that next week that would be something that we can think about.
- SC: Excellent, great.
- CN: Yeh, I think we just, it didn't drag but it just felt like we had enough time for the things that we did and I didn't want to kind of overload and put too much into the first week.
- SC: Good. So it was less is more.
- CN: Yeh, yeh.
- SC: But, did you have enough resources in the room?
- CN: Plenty actually, I was surprised.
- SC: What did you have, can you described what you had, as regards your musical resources?
- CN: Yeh, in terms of tuned percussion there was the xylophone and metal phone just not the chromatic notes.

SC: Diatonic

CN: Yeh, diatonic. And the base xylophone and then we had 3 sounding bowls around the room, one that was central to the group that we used at the beginning and then 2 that were kind of on the edge of the group, if you like. There was a small table with some hand held percussion instruments, energy chimes, Tibetan bells and I can't just think of everything..

SC: No, that's fine. And did they get used?

CN: They did. We did two lots of drumming at their request actually, they wanted to do something else and then we agreed that for the last 15 minutes they'd spend some time looking at the instruments that were there and trying the different sounds and playing different ways, yeh, just really exploring what was there. So they each picked something and came and sat back in the middle and then we had 5 minutes at the end. It was interesting because Jacob was talking about stockhausen(??) and bringing in a lot more of the intellectual musical thinking and knowledge and it was quite good actually because what he brought was about how he experiments with different sounds and he was quite surprised at how different sounds could come together and create something like he does, and so he was able to bring into the group and think about their experiences and them coming together and using the parallel really so.. so it worked quite well because they were all there and experimenting and Stephen has said at the beginning you know, we've never used these instruments before, he was wanting a bit of advice I think about how to play.

SC: So did you give him some?

CN: Yes.

SC: Lovely. How did you do that?

CN: He just asked us 'how do you play this' so we just talked together about the different ways that you can play and actually.

SC: Did you show him.

CN: Mmmm. But there is not right and wrong.

SC: Fabulous.

CN: Yeh, he actually passed me instruments like the singing bowl, he just handed it to me and I played it and then he said, what about like this? And then he played it in a different way.

SC: Excellent.

CN: So there was a lot of exploring going on but it wasn't that I was particularly saying throughout the session you know, be thinking about this, it just kind of happened that they were doing that.

- SC: So you were prepared to do little informal demos when they asked and do you think that gave them the confidence to try things themselves?
- CN: Yes. I think there was definitely anxiety about choosing the instruments and Shaun had said actually after the first piece of drumming they'd all been quite shocked at how well they'd all played so well together and seemed really pleased with themselves and then at that point Shaun said 'actually, I'd felt quite worried about playing' so we just thought you know about our experiences and I kind of was open actually about my experience and how it can be difficult in a new situation just to know what to do, to think about people's expectations and how people might feel.
- SC: So you were validating it's natural and normal to feel anxious, indeed you've worked through your anxieties before you prepared yourself and now you're preparing them in a way and helping them with a similar feeling. Just one thing before we leave that question for one of the patients to mention Stockhausen ?? it's quite a big thing, how did that affect other patients who might not ever have heard of Stockhausen?
- CN: Yeh, thinking back I should of probably, I don't know, I didn't really want him to go too far into it because I don't think he would have stopped.
- SC: So how do you think it affected the group? Don't worry about what you did, how did it affect the group?
- CN: I think they probably felt a bit inferior to him because he was demonstrating that he has a lot of knowledge.
- SC: So he was talking over their heads sort of thing?
- CN: Yeh.
- SC: Okay and yet you did an improvisation and you and I know that Stockhausen's music is very aleatory from the point of view and it has a degree of chance in it, in that there's different ways in interpretations and there's a lot of freedom in aleatory music, and so, the improvisation that followed after his 'big word' that didn't mean very much to the others, what was the feeling for the group then?
- CN: It was very reflective actually, it was very quiet and totally different to the drumming. There wasn't such a sense of a beat but they were all present and what was really interesting was that they didn't all want to play or need to play at the same time, Carl kept trying to play a bit with me and them responding, he wasn't just playing all the time and there was a sense that they were really listening to each other and bonding and interacting like really in other groups it can take quite a long time to reach that point and they were just doing it.
- SC: So how would you, it sounds as though you've done something like you've done something that's very containing in the first place, but how would you describe that main difference between following the manual in this group and your usual way of delivering music therapy?

- CN: More directive but tried not to be too directive, I still wanted to keep kind of psycho-dynamic approach at different levels about what was coming up and trying to bring it back to the group and the group process, so in that sense it wasn't any different, but I think yeh more directive and yeh like the time banding, having the time boundaries, having limited resources or for me the feeling that they were more limited than usual.
- SC: So did that make you anxious?
- CN: I was a bit purely because I thought we'd probably run out of things to do, and as it happened I was probably more mindful because they were being more encouraging mindfulness and there was something about everyone being mindful and you don't just move so quickly from one thing onto another. It felt there was a lot more thinking for everybody.
- SC: More thinking space?
- CN: Yeh.
- SC: So how did you employ mindfulness techniques?
- CN: Mmm.
- SC: Cos you've used that word.
- CN: Yeh, I just feel like there were awareness, they were quite aware of each other, it just felt that they were picking up on other people in the room who might have responded to something over there, and recognizing that things were happening in the music.
- SC: Now, am I right in thinking that they all have folders?
- CN: Yeh.
- SC: And does that have the 4 stages of C-Cant written so that they have something that actually suggests that the first 4 sessions are about mindfulness?
- CN: Mmmm.
- SC: Do you think that's useful?
- CN: They didn't seem too bothered about the folder actually. 4 of the 5 left the folder with me, which was quite interesting and as well the one that took the pink folder, I think there was a pink folder and I didn't know who to give it to, so that was a bit of a joke in the group.
- SC: Oh right, you didn't have the right colour.
- CN: Well pink for a man probably not, but I had to give it to somebody, so it went to Shaun and he kind of made a joke of it and that was okay, but, they did flick through it. From the assessment I didn't feel like overall people were that comfortable with the psycho-therapy file, I found it useful and I found that I could

relate the things they were saying to the psycho-therapy file. It almost seemed too much.

SC: Yes.

CN: We used the actual file with them.

SC: So that's something that will probably build up in scaffold way over the 16 sessions, its not as though it has all has to be completed at the moment. Were there any particular bits of the psycho-therapy file that you did find useful?

CN: Yeh, definitely the last page.

SC: Right.

CN: The different states and the second to last page, I've tried with a couple of patients to think what that is.

SC: That's also about state, self state. Was it useful in helping to formulate the target problem?

CN: Yeh, because it helps, I think straight away you going in and you kind of presenting the therapy of something more than just going in and playing some instruments and so from the beginning people are aware that there not just coming to have a bit of fun, I mean, hopefully they will but its not just about coming in and playing and going away and not thinking. And I think from that, from using the file they were more open to thinking a bit about themselves and the investment and that was helpful.

SC: So, being more open sounds excellent. You've more or less answered in your own words how you've modified your techniques and one of the things you've said was that you agreed with the group a time limit for the improvisations and that sounded to me as though it was quite empowering because it wasn't as though you had to stop the improvisation but everyone was thinking together and that you developed group consciousness and cohesiveness by all but agreeing, obviously they're on their best behaviour first session, and hopefully they won't agree later on and work with some conflicts, but are there any other ways in your own words in how you've modified your own techniques?

CN: I don't, I think the way that I played musically was slightly different, I just used the base bar and kept what I was doing quite simple and grounding and so what they did could be sounded above it.

SC: Did you feel overwhelmed at anytime?

CN: No, no I didn't and I don't know if that good or bad in the sense of what I might or might not have picked up, but actually I didn't it felt okay.

SC: But, does that tell us something about how the patients may not have felt overwhelmed?

- CN: They did say that they felt that it had been a positive session, they were really pleased and they weren't just talking to me either about other things that can happen that is not directed at the facilitator or the therapist, but they were talking to each other and kind of being encouraging to each other.
- SC: Excellent, fantastic, lovely. It sounds exciting. Lets look a little bit more precisely at patients behaviours if you like and what came up for them, so really, the first thing is, could patients observe, and it doesn't matter if they can't its just what happened, this is your group, okay. Could patients observe, describe and experiment with the instruments during the sessions and well, if they could, how did they do this, was it explicit in I'm observing this or I'm experimenting with this, or what it implicit in that you could see from what they were doing and that you have that evidence?
- CN: I think with Jacob it was implicit, there was a bell tree and I don't think he'd ever seen it before and another group member said I think you need to get the beaters, kind of told him how to get the beaters off the stands and then another one said oh you could always play it like it like you were playing the drum, you could of hit it either side like this and then he spent a couple of minutes really running the beaters up and down, he played the different bells and he said, again it came back to very musical skillful things, he was talking about tones and semi-tones and how they weren't actually notes. They were, I can't think of the word he used, were they're not even semi-tones..
- SC: Quarter-tone.
- CN: Quarter-tone.
- SC: Micro-tone
- CN: Micro-tone I think he used.
- SC: So he's trying to sort of demonstrate his academic knowledge isn't he and perhaps do something, but on the other hand other group members were showing him how to use the instruments, could he accept that?
- CN: Well, he did accept it because he took their advice.
- SC: Oh, good.
- CN: And he managed to get the beaters out and he did play for a bit.
- SC: So, any other patients in how they themselves observed, maybe Jacob looked at the bell tree and didn't know what to do and someone showed him what to do? Are there anymore examples that you've got of patients observing and then describing and then having a go?
- CN: I think with the sounding bowl that happened with each of them to a greater or lesser extent, but they were able to think about how it sounded, they were looking at it visually they were describing how people were playing it, how it made them feel, you know often people say it makes them feel relaxed its quite calming and peaceful.

SC: Did everyone play it, or how did you use it?

CN: Everyone did play it, I was a bit worried about Tom at the start because as I was showing the instruments I knew everybody but Carl had actually had an experience of playing and I was trying to say you might want to have a go now, some of you have had an opportunity in the assessment and I was going to pass it to Tom and it didn't feel right it felt like he was on the spot and so I didn't, but then he ended up then being at the end of a line of people who all had a go and then talked about it, and then it was like there was an expectation that he would do it, and at that point I felt a bit anxious for him, but he might feel a bit overwhelmed or pushed into it, and I think I commented on how it might have felt being the last and what he thought the group might expected of him to validate it.

SC: And what did he do?

CN: He did play, he went up and down in the scale, it was fairly structured I think in the sense that he did just play the scale to start with up, down, and then he went up swept up the strings and then back down again.

SC: Is this Carl we're talking about?

CN: No, Tom.

SC: Okay, I just wanted to check, and he hadn't played the instrument before?

CN: He'd had a go in the assessment. It was Carl who that hadn't.

SC: Yeh. Were there examples, lets think about how they didn't do this, how didn't observe, describe and experiment in session 1, because over the next 4 sessions the task is about encouraging their mindfulness in how they maybe able to come to observe, describe and experiment, okay. So clearly it wasn't, they were there they had a good experience, and there were observations but they were mainly implicit at this stage.

CN: There was some. No, that was Jacob I think though who was more implicit, I think more explicit for Stephen he was able to take hold of the bowl and feel it.

Tape turn over.

SC: You were just talking about Stephen and the sounding bowl.

CN: Yeh, they way he was using the sounding bowl was reflected on how it sounded and how it felt when it was in his lap, feeling the resonance and feeling it through his body and Tom said similar. Shaun commented on how it sounded and was able to take it, feel it. Tom even smelt it.

SC: Lovely.

CN: Yeh, smell the wood and some curiosity about where the wood had come from and origin.

- SC: Were they surprised by the origin?
- CN: Yeh, I think when I said that they were made in this country and there was one maker and I think I explained a bit about it. Jacob felt that it was an instrument that probably originated from hundreds of years ago and talked about Celtic music and..made links, Stephen is Scottish and talked about Celts in Scotland and got into the historical things, although he was bringing in this material at times it was quite useful because it was, although he might not have been conscious of it, he was bringing something about what was happening in the group or about making links you know.
- SC: So is there a link between the history of the instruments and what they might do in thinking about their own personal history do you think?
- CN: Mmm
- SC: And something about where they've come from, is that something that is probably not habit but its something that just happened in this session, I think what you are saying, there's rich material that the instruments are a kind of medium through which a theme seems to have developed, a theme about history, curiosity about history and there must be if projected in these instruments that one of these guys knowing very much about each other.
- CN: So they're all wondering about each others histories?
- SC: Maybe, who knows you'll find out one way or another. The last question is, what was the nature of you're experience of the therapist, so very much you when asking patients to observe, describe and explore, did you feel you were doing that implicitly?
- CN: Mmm.
- SC: Yeh?
- CN: Yeh.
- SC: How do you think you feel about making it more explicit over the next 3 weeks?
- CN: Yeh, I'll feel I don't have a problem with saying that, actually, I think there was just so much today in terms of introductory things to get into the session it wasn't kind of at the forefront, but I think it will be quite easy to move into being more explicit with that group.
- SC: That's just reminded me of another question, which has just flitted straight through my brain then. So, did you do anything, I'm going back to the general questions now, did you do anything as regarding ground rules?
- CN: They were brought up after the introductions we were thinking more generally about the group and them coming together and we did talk about, I'd brought into the group about how we need to make the group feel safe, it needs to be something that we work together to create something that feels safe and in order

to do that there needs to be some confidentiality in terms them not taking material outside the group.

SC: Great, so you're making that explicit.

CN: Yes. I talked about and then from that Shaun said, so are we going to do group rules now, and made some flippant remark about I think the ways in which they do in other groups, and I just put it 'well, that's the main thing from my perspective that I want to say right now' and then 'is there anything from your perspective about things that you would like from group members or things that you would like for us to discuss to make this feel like somewhere that's safe to bring material and I'm trying to think about what actually came up – I think the only thing that was said, was Carl said 'I'm alright, as long as nobody hits me', and I said that 'I would hope that's not going to happen, we don't want to have any silly outbursts'.

SC: So perhaps ground rules, that might happen in any group not just the G-Cant group, but basically he wants to be sure that no violence is tolerated.

CN: Yes.

SC: So we don't harm each other.

CN: Yes

SC: We don't harm the instruments? What about that?

CN: We did think about the instruments, and I said 'you know, I would hope that if anybody', Carl had already shared his negative thoughts and expressing them and I said I hope if there are these feelings that we can think about how we can express them through the music and do it in a way that is safe, so I didn't actually say don't harm the instruments but I did imply that you know, we needed to be careful as to how we used them.

SC: So do we have to express just safely or creatively, might they need permission to be able to express as times goes on their negative feelings which might be rather destructive, they might have to say how angry they feel, how they want to him something very hard or else we might losing something very important mighten we?

CN: I think they did hit things hard though today, it wasn't that things weren't coming up.

SC: So they were experimenting?

CN: Yeh they were, they were experimenting in different ways on the xylophones on using the beaters in different ways to create different sounds... not just playing things in the standard way, trying new ways, it was happening.

SC: So maybe over the next 3 weeks the fact that's happened and you'd be thinking about group commonalties and also uniqueness of each person being unique, that there will be different things happening in how the observing and describing in

the experimenting happened, I think we've got enough there Claire, I want to thank you very much today.

CN: Okay.

Appendix 6c: Semi Structured interview with Claire for the end of treatment stage (session 16)

15th December 2011

SC: Claire thank you very much indeed and congratulations for getting to the end of this stage. The questions or there are more of them but we have got to session 16 so I want to start with the basic ones now if you can just say just a few brief words about what it felt like in these final four sessions to follow the manual were you able to?

CN: I think on the whole I managed to follow the manual but I did find towards the end, it felt like there was an awful lot of material and things to be tried and introduced into the work, in these last sessions and I felt quite a lot of pressure to kind of make sure I'd done a lot of different things in terms of working with the diagram, working with reciprocal roles, obviously working through the music but also getting them to think about the ending as well. Just a lot of things to think about.

SC: How did you feel personally, because that was the sort of task you had to do, how did you feel personally at this final stage of treatment about following the manual?

CN: It was good to have the guidance and yes, it was useful to have the guidance but at times I did feel quite overwhelmed with what was being asked and whether I would be able to kind of fulfil everything that was in the manual, I kind of reached the point at the end where we'd done the things that I felt we needed to do, so maybe, I felt a bit of pressure in the sense that I wanted to achieve the things that were in the manual and I wasn't sure if my group would get that to that point.

SC: Ok thanks, how would you describe the main differences between following the manual and your usual way of delivering music therapy as regards completing; doing the ending at this stage?

- CN: There was a lot more focus on the diagram and thinking together as a group about the diagram, trying to identify for each of them; you know about their self-states and how they might go between different self-states and trying - I think I left a lot of the kind of CAT vocabulary, was left until later in the therapy and then it felt like there was a lot of new material. It seemed like new material that was kind of coming up in doing the diagram and I wondered if they were really understanding what I was asking? I think just that the fact that we were trying to do the diagram was very different, not something I had ever done before and actually as we worked towards the end it would become clearer and they would become able - they did become more able to work, with thinking about and using the diagram. Also the closure letter was something I had never done before.
- SC: So we called those farewell letters didn't we what sort effect did they have in delivering?
- CN: I think they seemed quite pleased with their letters that I'd written. They seemed pleased that I had recognised things in each of them and had taken; there were positive things to feed back also constructive things you know, on how they might move what they have learnt in the group forward into kind of every day life. I think they appreciated the fact that I'd spent time thinking about them as well and put time and effort into writing something that was quite personal.
- SC: Great, lovely. Can you describe in your own words how, a little bit about how you modified your technique for closure or farewell, I mean I think you have done actually by the letters?
- CN: Well yes by introducing all the structures by having the letters by kind of working with the diagrams and psychotherapy files and the self-states procedure, all of those things are modifications really of the way that I have worked in the past.
- SC: But how about in the music?
- CN: It was important - well something in the manual about being able to reach a collaborative ending, just being really mindful I think, of how the music was and where it was heading and how to kind of bring it back to a place that felt kind of contained and safe and that reflected something of the mood of the group which can be quite sad at the end.
- SC: Sounds very appropriate that it was sad. I just want to add a question in here, did you initiate themes, in the music to bring them into those appropriate moods to help them there.
- CN: Yes, I did use a motif. I played the metallophone, and I did A to C, C to D and just throughout I just kept at points just repeating that phrase and actually the music kind of swelled and grew. Sometimes it wasn't so easily heard and then as it kind of died down it was just there and present and it did help actually, it helped me as well to kind of stop myself from becoming quite chaotic potentially and doing too much into individual people, peoples' music - it kind of kept me grounded.
- SC: But using those notes are you saying that it's a motif that also potentially can create a cadence or a point of repose in the music. A stop bath???

- CN I think it did and because of the notes that I used, it had a minor feel to it and I think it helped them maybe - it encouraged maybe a more reflective mood in the music.
- SC Well done, super. Let's go on, these will be fairly short questions just recapping from the things they learnt earlier in the group. Do you feel that your patients at this late stage could still observe, describe and experiment with the instruments and if so how?
- CN There were I think throughout actually, they managed to observe and really kind of look and study different instruments they've always been quite curious about how things have been made and thinking about where they might have been made and you know the textures and the look, kind of likening instruments or sounds to other things.
- SC Oh really
- CN Yes
- SC Can you give me an example of that?
- Just that without breeching any confidentiality just of how between one sense, the visual sense ?
- CN Its hard to think of an example the only one I have got which was a bit, it wasn't a particularly good example really, was the sounding bowl. It kind of reminded somebody of barbed wire. It was in the last session it brought back the theme of barbed wire and the fences and the boundaries - the physical boundaries and yeh the differences between prison and Rampton hospital that doesn't actually have the barbed wire, it was quite a bizarre thing to say but it was juts something that came up.
- SC Interesting, very fascinating because there are wired strings on the sounding bowl but they're not barbed - was that the imagery that they were getting at that here its gentle it's not as....
- CN I think it was because there was a recognition that actually Rampton wouldn't have the barbed wire.
- SC Yes
- CN You know if you've been somewhere there's been barbed wire like a prison and then come to somewhere where there is none.
- SC And it's not a confining sort of wire, it's an expressive sort of wire on a sounding bowl?
- CN Yes
- SC Lovely, thank you. Were there any of them that couldn't observe, describe and experiment at this stage?

- CN I think they've all been able to its hard to just pick out examples right now but I think probably, if I think back I'll be able to find. They have all been quite abstract in their thinking.
- SC Yes, good.
- CN And Jacob certainly said in the last session that something he's really appreciated being able to be quite abstract and think in a different way and to just feel quite expressive in his use of language in the music. Yep I think for all of them, they've managed to do that.
- SC What was the nature of your experience as a Therapist when they observed, described and explore anything to add or shall we move forward from there?
- CN I don't think I have anything to add.
- SC Ok. So let's move on. The stage two is really about emotional regulation and that was quite a while back but did you find that patients could still engage in turn taking?
- CN They were definitely listening to each other, they could all pick out at different points in the music where they might have noticed somebody else and done something in response. It doesn't happen all of the time but they - you know, in every piece we've played, afterwards they've noticed and then commented upon each other.
- SC Wonderful, do they do turn taking with primarily with you; the therapist or with other people?
- CN No it's not been just with me, I think they have made connections with each other. I know for Tom he particularly enjoyed using Djembe drums and at different points all of the others in the group did have quite solid and fun interactions with him through the drumming, but yes, it has happened on other instruments as well.
- SC Great, and what about the sound print, did any of them maintain their unique identity through an instrument of a kind of a sound print or a safe place to go or was that discarded as time went on?
- CN It felt like it never really took off the idea of the sound print. It's never been discarded because I've always brought it back but its never seemed that people have just settled with one instrument they've seemed to kind of go between instruments in every piece of music.
- SC OK
- CN I think though as we look back we'll probably notice that there are instruments that people favour, I know Tom favoured the Djembe drums and Stevie enjoyed using the sounding bowl and possibly Karl the guitar and I think for Jacob the

piano was introduced just for the last four sessions. I think that would be his sound print.

SC Wow that really interesting actually because of course he can play the piano and he earned it didn't he, Yeh

CN And he used it really respectfully as well in the group and he was very aware of how he might come across if he was to just play how he wanted to and I think you know he kind of reined himself in at times and was quite responsive to the group.

SC Well bravo to you for helping him with that. Did you find that patients could make verbal links between the music they made and their emotional state?

CN I think that was quite difficult for some of the patients in my group, I think Stevie has managed to do that more than probably the others, I think he has been quite in touch with his feelings and his own ways. The others, I would say Karl's been able to recognise in other people, feelings and has able to reflect on other people more easily than he's been able to reflect on himself.

SC Ok.

CN I think Jacob talked about at times feeling quite muddled and like there's a pressure something pressing on his mind which mean he can't say or express what he wants and I think he found through music that he's been able to express in a way that he can't verbally so that's invaluable to him.

SC Fantastic what feedback. Again congratulations to you. You've given me some very good examples there. Were patients able to say what they hoped to get out of the group work treatment?

CN From the very beginning?

SC Well from about session five.

CN I think they were aware of their target aims, not all agreed I think there were a couple that did not work collaboratively and I think that was a problem actually because they didn't agree with what I'd chosen as their target problem their target aim. But I think on the whole they were all able to recognise - and something I kept coming back to was about connecting; connecting within themselves and connecting outwardly with other people and that seemed to be one of the main things that we focused on and thought about and they did grasp that.

SC Excellent, thank you. With your experience what did you find most useful in facilitating musical to verbal connection?

CN What did I find useful?

SC Yes in making a bridge or a link between a musical?

CN I think it goes back to the early sessions of just observing really and describing what I see or what I heard or how I felt and at times where it has been difficult for

others to say, that I might have kind of fed something back to encourage people to do the same.

SC Did that include any subjective feelings?

CN Um

SC It did, sort of around the mood of the music?

CN Yes, yes or about a feeling I'd had as I'd been playing you know in the last session when somebody had been talking about the sea and kind of feeling like it was drifting at times and I had the sense as a kind of wholeness you know like the sea just like the staff xxx and kind of being in it and it was almost like it was washing over us at times and then there was this ebb and flow and it kind of felt ok just to be in it and not responding to individuals but just being in it.

SC Wow beautiful. And that happened right at the end of session sixteen, that's very different from the beginning isn't it. Let's think about the distress tolerance and how that manifested in the group. At what point do you think during the sixteen sessions could patients make any verbal link between the music that they made and their emotional state?

CN I think it at times its present more so if one of them has felt particularly angry or there's been a really strong feeling

SC Yes

CN With one group member, it seemed easier to kind of work with that feeling and what someone was bringing and what people are able to recognise.

SC Yes

CN The feeling which might be anger or frustration and they've been able to think about it but I don't know for maybe more subtle moods and feelings, I don't know how easy that's been. I think the music acted more as a way on a different level to kind of bring everybody together or kind of tune people into each other if you like.

SC Yes

CN Without really saying too much about it afterwards. They've kind of just help the conversation after.

SC Wonderful that's really good but I think with this patient group being able to express anger and frustration is pretty crucial isn't it. And it may not be about subtlety it might be about things that need to be contained within the music that aren't at all subtle. Did you find that patients could reflect on the impact of loud sound and dissonance?

CN They did talk. We particularly used the gong there was a session - I think it might have been session fourteen

SC Yes

CN Or fifteen, it was towards the end anyway and each of them used the gong and it was the first week that Stevie had used the gong and we did think as a group about the experience of hearing the gong and being the one to hit the gong and yes just thinking about the power of the sound and how it felt you know, what was it expressing, did it just have to be angry or could it be about something else? Would it be about empowering somebody or I don't know there were lots of things and we did kind of focus down on that one instrument because it just seemed relevant to use that you know think about overwhelming and overwhelmed into possibly somebody wanting to take control of the music by doing something so big.

SC And so they could describe, could they describe their subjective experience of loud sounds?

CN A couple did, Tom managed; Karl not so much but yes Tom and Stevie and Jacob all managed to really kind of think about how it felt to play, I know for Jacob he said it reminded him of the film, at the beginning of the film's where they hit the gong and there's the big man with the muscles and that kind of who he, he kind of wants to be, that big strong man but actually it made him reflect on the fact that he feels like a child a lot of the time.

SC Right

CN So it brought in a lot of other material.

SC It did didn't it. And could they all engage in creating loud or abrasive sounds make links with their internal state of feeling?

CN We have had improvisations that have felt, that have just been very loud and quite busy really but it seemed that everybody's been part of it. It's not been that somebody has been switching off or not wanting to do it, it's felt like a group.

SC And what stage was that roughly, which session when they could play loudly like that and abrasively?

CN Probably from about session ten, I think.

SC Excellent, great, good right in the middle of the distress tolerance stage then? Good, did you feel able to facilitate and contain mediate and support the creation and the resolution of loud or dissonant sounds within the musical improvisation, if so how did you do it?

CN I think as much as anything, there were points when it was important to withstand the sounds - certain powerful sounds just to be present and to just remain there and quite firm and grounded and then I think there were at times where it felt appropriate to kind of match or to meet that energy and to do something equally as wild or as you know to have the same kind of mood. But that's how I've managed it and I think ultimately when we have improvisations that have had really really loud powerful bits to the music it kind of subsided and by the end it been very different it's gone into something more reflective.

- SC Good so it has resolved?
- CN Yes
- SC And just before we leave that stage, how long have the improvisations become, I'm wondering about their duration?
- CN I do believe twenty minutes.
- SC Really?
- CN Yes, they've not felt so long actually as we've been playing its not felt like a long time but quite often, I know Tom's noticed and he's played for twenty minutes or so.
- SC So has the duration of the improvisation changed since you started these sessions?
- CN Well I earlier on I think I used to put more of a limit on the time so that we would keep it in maybe ten minutes and then talk where as in the later sessions it was much freer and it was just about allowing things to grow and develop and to just see where it took us.
- SC Lovely; and we're onto the final stage, thinking about personal effectiveness. We're also thinking now if they could still turn take and whether you felt able to facilitate and contain those loud sounds still and what musical techniques you may have added or were helpful at this stage when we are thinking more about ending, for instance plagal or perfect cabal or a ground base or sounding bowl or base xylophone or a sound print?
- CN I think it's probably similar to what I've already said you know to just to kind of have a motif and yes to kind of resolve it you know towards the end kind of feel like musically it's closed.
- SC Yes
- CN You know towards the end kind of feel like musically it closed in a way, it wasn't left open.
- SC The motif you were talking about earlier you mean the 'A,C,D' ?
- CN But that did kind of resolve itself but I'm trying to think if I've done anything else.
- SC But you introduced that motif I think recently in this last stage so were you not using that credential type of motif earlier in earlier sessions?
- CN I've used the base bars G and C or F and C
- SC Got you, yes.

- CN As a way of kind of sometimes hammering home to cover the end up, you know if it feels like it needs to reach a conclusion quickly.
- SC Right.
- CN To encourage things.
- SC Good, one thing here. Oh, excuse me a minute... OK so finally Claire, can you tell me anything about how patients use their choices or perhaps favourites or their own voice or whatever in thinking about how to express the ending of the group, the farewell?
- CN I think Karl was quite happy to write something down, he's very comfortable writing anyway and he did write some quite insightful reflections about each member of the group and about me as well as the facilitator and about what he felt he had gained from the sessions. Jacob just talked about, he didn't prepare anything, but he did share that he felt he found the group valuable, he's able to express himself better through music than through the use of words and he felt that he it was ok to speak in an abstract way and to think in an abstract way and he was kind of comparing it to other areas where maybe he doesn't get that opportunity. So he was feeling quite sad I think that that was not going to be happening any more.
- SC Could they actually say goodbye?
- CN They did say goodbye and they shook hands at the end of the session.
- SC Yes?
- CN Yes they did, they all kind of said little bits to each other and actually there was a lot of humour something I could just find it - there's something that Karl wrote which I thought Jacob might take in a really bad way, but actually it was quite humorous the way that Karl had written it, you've got; "***Jake it's been great to see you as lucid as you have been following the music we have made I feel that you are a genius who can speak far more eloquently with music than you can with words. As is often the case where there is genius there is madness; I have had the pleasure of seeing both in you, Thank you.***" And I mean those obviously can take bits of that in different ways but actually there was some real humour around that and Jacob was aware that actually they'd shared time together when they'd both been admitted to the hospital. Karl was reflecting on a time when they were both really ill and they had been quite unsettled and disturbed and yes just recognising what he had brought to the group but I think there was a lot of humour between each of the patients possibly as a way kind of managing the feelings.
- SC Quite a sudden ending.
- CN Yes.
- SC And finally how do you feel about the closure of the group?

- CN I'm sad, I will miss the group and I don't know if having more sessions would be better. I kind of feel like I would have liked to have had more sessions with the group or a bit longer to work through the same amount of material.
- SC Yes.
- CN So it hadn't felt so kind of pressured. It did really towards the end - to fit it all in. But having said that I don't know even if I had an extra four sessions that it might still have felt pressured at the very end because of the nature of the ending.
- SC Yes; yes.
- CN That was my only thing that I wish I could have worked with them for longer and I know that they wanted to work for longer and there was a xxx
- SC And how did you find doing the closure letters?
- CN Once I got going with them and I kind of had an idea it was not too bad actually I think Karl's was the hardest to write. It was harder to really think about his process than maybe to think about the others in the group.
- SC Good.
- CN Yes I feel that it's something that I'd like to use again actually.
- SC Well Claire thank you very, very much indeed that's very rich information that you've given there which will be very useful for many people after the project's finished and really contributes to the treatment manual. I feel deeply moved and full of gratitude to you, really do.

Appendix 6d: Semi Structured interview with Victoria for the end of treatment stage (session 16)

15th December 2011

- SC Following the 16th and the final weekly session of the group of Cognitive and Music Therapy project and I want to thank you very much for all your hard work to date – really amazing and I have quite a few questions and I want to go back to think a little bit about what it was like at the beginning and then work through to the ending.
- SC Firstly, we are going to look at the general questions which I am going to ask you – so at Session 16 regarding the treatment manual – can you describe generally what was it like to follow the manual in delivering music therapy?
- VS I think at this stage, it was probably more helpful than it has been in earlier sessions because you really needed to have some guidance on things that were really, really new at this point and we were doing a lot of mapping sessions and so it really did help with that really.
- SC Can I just ask about that – we covered a lot of mapping in supervision – in your view would it be useful to have a bit more guidance in the manual about the mapping process?
- VS I think so and I think it would be useful to have templates in the manual to help people map it is such a different skill to what we are used to doing.
- SC Whilst we are on that subject within the manual, can we think about how the mapping occurred? We did mapping in supervision, how about within the group?
- VS In my group we were quite structured in nature, and we actually went to the table to map but it was generally following the improvisations helped us to play both together and then we would go to the table and begin to think in more cognitive ways. So it kind of freed things up through the playing and then I think that actually the focus of the map to help them look at something and bounce ideas off each other was really, really useful because very often someone would say something and then another person would be able to relate that and maybe explore a little bit more about themselves so that might be an experience that they have had on the ward about feeling controlled and someone else might say that “yeah I agree with that but I can go that one step further and I end up in seclusion by acting this way”. So while they were talking, I was able to write things on to agree and cross things out.
- SC So did that help them to realize how the pattern or procedure on how they got into seclusion for example?
- VS Yes I think so, I think it really helped them to put the process together with the little links in place and also maybe to recognize how they would use the map in the future with something that came up in my group, could they take that map and look that way at where they might be, you know I would suggest that following supervision that they might want to use it in a ward round situation and

they could really relate to that as sometimes they cant articulate how they are feeling but they could see on their map.

SC Good so that are using a different sense they are using their visual sense with the mapping, their auditory senses for the music making. Do you think the mapping makes a connection between those two then?

VS Definitely because we were able to think what was happening in our improvisations and relate it to the map so it might be that behavior was being mapped and I could maybe suggest could you do that in the music and then they could think about how they played with each other and see if that was happening on our map and they might add to it from that.

SC So how would you add an auditory experience of music making onto a map?

VS Good question – I guess really it was more about drawing a theme or the feeling very often actually. What did you feel and actually just writing that down, it doesn't have to be really complicated it was more about a thought.

SC A subjective feeling?

VS Yes.

SC OK. How would you describe the main differences between following the manual and your usual way of delivering music therapy. We are thinking now in the final four sessions really.

VS It was very different, although we would work towards the closure, following the manual and doing an ending method was something very new. Bringing all the different materials together where as I think normally you would say much more in the music and there might be a lot more silence as it is a bit more directed and we were able to have a pathway almost to how we would close the sessions itself. It felt like we had something to hang on to actually like the language as well gave us something to hook onto and think about or to try and think about ending.

SC But the verbal language not just the musical language.

VS Yes.

SC Did the musical language help you think about the ending as well, do you think there is anything to do with the emotions to do with farewell.

VS I think that came out very much so in that final session through the music through them not going there. It was unspoken.

SC OK. Do you want to say a little bit more about that?

VS I was just thinking about the way that Oscar, particularly, acted in the music and how he was actually verbally relating which was very different to how he was musically relating.

- SC What was he doing in the music?
- VS He was being quite overwhelming in the music and trying, I think trying to be the best most of the time really and not being so aware of what others were doing and seeking attention as well.
- SC Does it suggest that an ending for him was, that he himself was feeling overwhelmed by the feeling of ending?
- VS Yes and I think having reflected on it, it may fit with his experience of a recent bereavement of his father as well so there was an awful lot going on for him and things that never really have been resolved I don't think.
- SC So can you describe in your own words how you modified your techniques over these last four sessions which are about interpersonal effectiveness and distress tolerance really?
- VS I think I was a lot more direct with the language that I used. I think I might have hidden more in metaphor normally than what I did this time. I felt more able to say things to them that I would have felt frightened of saying before actually. Perhaps how they related, perhaps they needed to think a bit more about ways in which they were overwhelming for example or that they could see that they had shared some vulnerabilities I might never have articulated that at that point in therapy because of the fear maybe of scaring them but I it was incredible being able to do that with them and having that ending letter was really powerful for a lot of them and to see them finally having something of their own.
- SC So you say that you mentioned fear and perhaps just thinking openly about the fear of ending, it feels to me that there is something here around how you did modify your technique but you were able to incorporate the emotion of fear?
- VS I think that came through more musically and we were able to think a little bit about what it felt like to finish and that was kind of encapsulated I think in the few moments of silence more than anything, just being together.
- SC And what was the quality of the silence?
- VS Just very reflective it felt safe to be together in that silence whereas maybe in previous sessions it had been more scary and the mood had said something.
- SC So was the final session or the last 4 sessions as to regard to the use of silence and the quality of the silence?
- VS It was creeping in towards the end definitely the last two sessions it was there.
- SC Very interesting – Great.

Lets just recap now, just going back and thinking the first of our pillars was in mindfulness and whether mindfulness still existed at the end whether we had built up layers or not, so in the final 4 sessions could patients observe, describe and experiment with the instruments?

- VS I think they could observe and actually they did do quite a bit of experimentation; although they seemed to stick, they found their sand print that they felt happy with. I think they were being more mindful in the quality of their playing there was more space in the music it wasn't a clamor of sound and yes they were experimenting for example, David on the guitar he was experimenting how he could use his fingers on the fret board. Not to make the physical... playing the wooden parts of instruments started happening a lot and lots of communication like that which was quite fun actually.
- SC Good. Were any of them not able to observe, describe and experiment at the end?
- VS Not really, I think all of them did in their own way.
- SC And what was the nature of your experience as a Therapist asking them to do that?
- VS It was OK, it got easier, it felt a bit strange in the very first sessions and telling people what am I asking them to do, maybe I need to do this myself.
- SC Definitely.
- VS But then we became more comfortable with it I think – especially as the sessions moved on.
- SC If we move towards emotional regulation now, thinking about that. I am wondering did patients find a favorite instrument to use as a safety call or sound print.
- VS They did, they all established their own sound print and that became evident in the last four sessions.
- SC Really – can you tell me what they were?
- VS For David it was the guitar, Oscar it was the pipedream, for Ben it was the Cymbal and for Mick it was either djembe or the bass xylophone. He was more comfortable on the djembe – that's what he described it as anyway.
- SC So did they call them their sound prints?
- VS Yes but we didn't use them as a safety call, it seemed to turn into more of their identity actually.
- SC Fabulous – that is what we are after. Lovely. Ok were they still sorry forgive me I have already asked that question you have answered me that they could still observe and experiment even if this last stage. We introduced the business of musical turn taking in stage 2 of emotional regulation. Could patients turn take and how did that develop in the last four sessions?
- VS I did think they learned and they did say to each other that they learnt to want to hear what they actually had been speaking and to hear each other and they were able to articulate for example: Ben would say to Mick that when I can hear you

now, I can hear you now and another example would be David would play very quietly on the guitar but there was always the space at the end for him to come through perhaps where he could make his presence felt more and play in a more supported sound. So I think they were able to turn take. The very final session was difficult and with Oscar it was quite overwhelming because that did close down some space in the music.

SC Were patients able to say what they were able to say what they hoped to get out of this group treatment?

VS We did think about the final few questions but for most of them it was about having space to be together in the music and it helped with group work as it was very different to other groups. One example is when Mick said I can actually tolerate people now and it doesn't make me angry.

SC That is lovely. He has had to tolerate a lot within the group I guess. Could you and the patient formulate your target aims – did you do those together and which ones were together and which ones did you do without?

VS Mainly together, Oscar's I formulated as part of the assessment but we have some thoughts together it was more putting it into sentence structure and they did share those with the group and we did come back to them at the end and he looked at them and thought about had we achieved at least some of it if not all of it and actually they all felt that they did achieve something. I think from my own personal development, Oscar's was too complicated.

SC Yes. OK.

So of your experience, what did you find most useful in facilitating musical to verbal connection?

VS Actually I think they did it themselves, they became able to reflect after the improvisations and I just allowed that to happen and took more of a passive stance I suppose at the start and then they introduced some ideas afterwards but certainly the mapping was the thing for me it really helped me. It helped me as much as them I think actually.

SC Well if we understand it, it means that we have to understand it before they can understand it that is the important thing isn't it?

Moving on as regards distress tolerance, could patients make verbal links between the music and their emotional states at this stage?

VS I think that was more difficult, it's hard for them to link actually with their feelings but there were some poignant moments when they could. I mean Oscar was brilliant at sharing his loss that he has had in the music or being able to share the cruelty.

SC When you say sharing his loss, did he share it through how he expressed himself in the music did he actually feel it or did he just talk about it?

- VS I think he felt it because he was able to articulate after playing he might be playing very quietly and would have quite a closed interaction maybe where I could feel that we were attuned you know we were linked and he had been playing in a much softer way I think and I think he did feel it and I think that's why the final session was so difficult for him because, because we had come along side each other and he had come along side other people in the group as well which was important.
- SC In music making?
- VS In music making yes.
- SC In those penultimate sessions?
- VS Yes, he didn't have to always be the one giving.
- SC Right.
- VS He could start to receive.
- SC Right yes, that's very fine. Could patients reflect on the impact of loud sounds and dissonance Victoria?
- VS I don't know whether really that was a theme in our group, we didn't have such load bashing sounds we did have some dissonance but it was more about feeling overwhelmed more about having a space.
- SC Well that is distress if ones feeling overwhelmed, is it not?
- VS Yes.
- SC Could anyone articulate that honestly?
- VS David was able to say "I couldn't hear myself think"
- SC Right, good, yes. So that was one of their subjective experiences of loud sounds to be able to say "I can't hear myself think".
- VS Yes.
- SC Yes, at those points were they able to use their safety call?
- VS I think what happened was we discussed more about stopping playing, actually feeling that you don't just have to soldier on in the music but you can stop and make space for yourself and sit back and look.

SV Could they all engage in creating louder abrasive sounds and make links with their internal state of feeling?

There's two halves to that question mainly.

VS I don't know that, well, we did have load and abrasive sounds mainly on the piano, actually more on the piano than anything.

SV Did all of them do or did just one person be the loud person?

VS No, actually Ben was loud at times with a crash or a bang but yes Oscar was more loud than anybody, he had a wave of loudness.

SC OK, as the Therapist, did you feel able to facilitate, contain mediate and support the creation and resolution of load or distant sounds within musical improvisation?

VS It was hard work.

SC How did you do it?

VS I just matched really or I used an instrument that I felt would come through the music so that it would offer some sort of guide for the other people in there as well.

SC Such as?

VS In the last session I used a recorder; treble recorder.

SC Very voice like?

VS Yes. I used the piano a lot in the penultimate session because the group wanted me to use the piano.

SC Yes. Did you link the music created to the emotional content of the session?

VS Yes I think certainly in the final two sessions that were able to think more about that.

SC What was the emotional content, can you describe any examples?

VS Some of it was joy actually some was actually when we got it together what did that feel like, you know; how was it that each person felt that they had linked it. It was a lovely just a really warm feeling to have that shared experience. It was just amazing and then there were some more you know, more difficult times there. Actually it was just about saying we weren't quite together or what was going on there.

SC Ok, so there were emotional links found. So in the last four sessions when we're thinking of interpersonal effectiveness could we still engage in turn-taking?

VS Yes, I think they became more and more aware of that.

- SC And bearing in mind you were working towards ending at this stage and we really only had three sessions to prepare the ending. I'm wondering if you can describe any of the musical techniques which may have been helpful for you, for instance; whether the plagal or perfect cadence, motif or ground base any particular instrument for the sound print?
- VS I think for me it was about having really grounded notes – big open chords to start with.
- SC Yes.
- VS As a group we talked about having a bit of the rhythm section as the grounding and one person took that on Ben for example in the cymbal very much so. But for me I've tried to use melody quite a lot and having a big range; the piano is good for that because I could make different sounds to make different instruments'.
- SC And were you linking with particular different instruments or different people behind the instruments?
- VS More behind the people behind the instruments but that helped me do that I think.
- SC By using the piano?
- VS Definitely yes.
- SC Did you use the piano throughout the project or when did you introduce it?
- VS I didn't introduce it until session five.
- SC Right.
- VS And to be honest it sat dormant for much of the middle part of the group it was only in the final part that it really became an active instrument and everybody tried playing it which was lovely so.
- SC So it wasn't just your property.
- VS No.
- SC Well we're nearly to the end of the interview, just need to think about the actual farewell and if there's any thing to add in; how did your patients choose to say good bye?
- VS My patients didn't write anything they chose to use music, we agreed that each person would begin a piece and we would follow as a group and we would try to integrate and that would be how they said goodbye to each other and we went round and did it that way.
- SC Could people as it were attune to whoever's improvisation it was and connect with them?

- VS Generally although Oscar was in a different place; he was struggling, in fact for his piece he stopped it which was exactly what he did in the assessment session I realized.
- SC Really?
- VS He put his hand out and said “No” and that is exactly what he did in the assessment session. It was like he’d come full circle with the hand gesture. It wasn’t until after the session that I realized that though. It was as if he couldn’t allow people to support him at that point it was just too much I think.
- SC Very moving isn’t it?
- VS Yes, it was very hard for him.
- SC Do you think he was holding himself together?
- VS I think so because for him he said immediately when he got in the space “This is our last session”. He obviously needed to kind of spill it out – we hadn’t even really sat down before he said it.
- SC And how about the things you did to close that were different to an ordinary closure?
- VS That was very much really around that group map, having a group map. Having something they could take away to reflect on like that was really helpful, having pragmatic discussions about what shall we do with the music; do we leave it here in the room, do we want to copy it, how does it feel?
- SC Could they remember their target aims?
- VS Yes they did, most of them did, in fact all of them at some level it might not be in the exact words but they had engaged with them.
- SC And could they say goodbye at the end of that final session.
- VS They all said goodbye and thank you, it was as if it was difficult, it felt huge actually and painful because those things are sad.
- SC Do you think they engage with some of the sadness or are you carrying it all?
- VS I think they did I think for some of them, especially David in the way that he played his instrument it was so different. I’m sure I was carrying some of the sadness but not all of it.
- SC Well the project’s is not finished yet because there is going to be a follow up session and Victoria, I want to thank you from the bottom of my heart for all your amazing work and commitment week on week in this project and I’ve been very moved with gratitude.
- VS Thank you.

Appendix 7 Subsequent enhancements to the treatment manual.

This chapter will describe the enhancements to the research project treatment manual as developed from the results. It gives an overview of the structure and format of the G-CAMT programme that is now being used for clinical treatment at the research site.

Further to the research findings, the overall aims of the treatment programme, selection criteria and structure have been clarified and they are described here in the way that they have been presented to stakeholders; the four treatment stages were reviewed and re-organised following the research project and their objectives are outlined. The tasks for each stage have been reviewed, common reciprocal roles that emerged at certain stages of the research project have been named, additional CAT tools for ongoing clinical evaluation of the therapeutic process, which it was not possible to use in the research study, are suggested. The purpose of the sessions within each of the four stages has been summarized. Guidance is given for patients about the meaning of each of the stages and how to understand the principles of mindfulness, emotional recognition, interpersonal effectiveness and conflict resolution. Outcome measures for service evaluation and clinical change have been named.

7.1.The evidence- based Manual for Group Cognitive Analytic Music Therapy

7.1.1 Information for Stakeholders

Hervey and Odell Miller (2013) state in their qualitative research with staff working with patients with severe and dangerous personality disorder, that the specific elements of psychoanalytically informed music therapy are likely to present challenges to forensic teams and patients. Seiser and Wastell (2002) state that an integration of techniques that work in harmony with each other can advance the patient's goals. The benefit is derived from not just the approaches or techniques, but also from the sequence in which they are designed and planned. (Lawday & Compton 2013) state that within the overall multi – disciplinary treatment approach, by balancing the principles of validation and change, a series of treatment phases can be coordinated. Cognitive analytic music therapy has been clinically tested in the present study to be compatible with offence -related, cognitive, psychosocial, educational and occupational therapeutic treatment programmes.

This Programme has a pre-agreed time limit and it is delivered to a clinical treatment manual that is structured to meet the needs of clinicians and patients in secure hospital settings.

(Compton Dickinson, Adlam & Odell-Miller 2013) The model was developed over ten years through a clinical and academic, ethically approved research programme which was supervised at the Institute of Psychiatry, Centre for the Economics of Mental and Physical Health (CEMPH) in collaboration with Anglia Ruskin University, Cambridge. The process of research followed the Medical Research Guidance for developing a complex intervention. (Campbell et. al 2007). The

developmental, modeling and piloting stages were conducted at a high secure and a medium secure hospital to explore the following statements:

- G-CAMT is compatible within over-arching MDT cognitive behavioural and dialectical behavioural programmes for the treatment of patients who have committed violent offences.
- G-CAMT is delivered in a group format, having incorporated learning and development from international developments of music therapy over the past decade.

Making best use of both cognitive and analytic concepts the model follows established clinical group work practice in forensic mental health (Adlam, 2012), applying Foulkes (1964) model; modified for the secure hospital treatment context (Compton Dickinson 2015 in press) by integrating the cognitive analytic tools and structures of Cognitive Analytic Therapy (Ryle and Kerr 2002). Mapping techniques may be new to music therapists. This aspect is covered in CAT clinical supervision as reciprocal roles and self- states emerge. Music Therapists without specialist supervision are invited to work collaboratively with their patients to draw out any aspects or issues which emerge, thereby using their improvisational creativity for visual as well as aural recognition.

7.1.2. Summary of the treatment programme:

G-CAMT focuses on facilitating the creative, musical expression of each patient working in dialogue with the Music Therapist.

- Reduces risk of violent acting out, through developing self-reflection and musically mediated group interactions.
- Uses mindfulness and grounding techniques, cognitive mapping techniques and jointly-created musical improvisation
- Considers creative and positive as well as outmoded and negative relating patterns.
- The objective is to recognize and revise dysfunctional relational patterns that can be observed in jointly created musical improvisation and through the use of metaphor.
- . Each individual becomes more aware of self and others and able to address issues in an adult state.
- Emotional recognition is encouraged through reciprocal relating as the group jointly creates their own music and discovers how to connect with their feelings and to share in harmony.

- G-CAMT is a group work model which is dialogical in nature: structured to safely address inter-personal conflicts with minimal risk
- The music therapist build on the musical techniques described in the manual to facilitate emotional relatedness, distress tolerance and to address the difficulties that patients encounter in coming to terms with loss and closure.
- Inter-personal effectiveness develops through joint activity, which includes cognitive mapping as a group to create a Group CAT diagram.
- CAT diagrams are made as a group with the therapist to aid recognition of individual and group reciprocal relating procedures as well as to identify unhelpful 'self-states' which are common for people who have committed offences,
- The objective of jointly-created musical improvisation and mapping is to create a bridge between the verbal and non verbal aspects mental functioning by which mental integration is promoted between the potentially dissociated self-states of victim and perpetrator. The purpose is to achieve a state of reduced impulsivity and greater ability of self-reflection thereby creating a greater overall sense of being all of one piece for each individual in his self to self relationship and in his relationship to others.
- The patient's views and choices are central in developing group dialogues and relationships

7.1.3. Selection Criteria:

- Suitable for In -patients with primary diagnoses of schizophrenia and personality disorder.
- Suitable for treatment resistant, long-term patients in secure hospital treatment in preparation towards conditions of lower security.
- Prior experience of group work is not necessary.
- G-CAMT can provide an introduction to group-work.
- Patient's benefit through discovering safe, non-verbal, creative modes of emotional expression and social relating.
- The MDT refer patients so that G-CAMT is an agreed and integral part of the individual patients's MDT treatment.
- Patients are initially supported at an individual consultation; there is no obligation or early commitment required.
- The music therapist gives a clear explanation from the Arts Therapies perspective. He or she is there to answer questions.

7.2. The Four Stages of Treatment:

The treatment duration is pre-agreed by the music therapist with the MDT. This is flexible and depends on the level of security at which the patient is receiving treatment, the risks of violence

that the patient may pose and the individual stage of psychological development that the patient has reached.

8 sessions in low secure, 16- 24 sessions in medium secure, 24- 32 sessions in high secure treatment settings.

The manual is followed over four stages each stage of which will consist of from two to eight sessions depending on the level of security of the treatment setting.

Stage 1: Techniques for Mindfulness and jointly creating music

Stage 2: Emotional regulation

Stage 3: Interpersonal effectiveness

Stage 4: Distress Tolerance and Conflict Resolution

These qualities are built up gradually as the treatment progresses.

7.2.1. Initial Consultation/Screening follows referral.

- Introduces the Patient to what happens in Group Cognitive Analytic Music Therapy.
- Explores patient expectations and needs.

7.2.2. Initial Individual Assessment

Process Tool: the Psychotherapy File

- Introduces the Patient to drumming, to a sensory experience through the use of the sounding bowl, and to a hand –held tuned percussion.
- Target problem and target aims are formulated with the patient, thereby providing clarity about what they would like to achieve towards their recovery

7.2.3. Treatment Stage 1 Sessions 1-6: Mindfulness. Being present.

Recognition task

1. Understanding the concept of reciprocal roles: Rejected- Rejecting. Judging –Judged.
2. Understanding of what is 'good enough'
3. Identifying and talking about 'Zombie States' and other Self- States such a victim state.
4. Music Therapists observe for dissociative states, anxiety symptoms, and encourage listening and turn taking. She will facilitate dialogue between herself and group members the purpose of which is so that patients can learn from the more experienced others, and to develop an ability to ask for help.

Purpose of sessions:

Establishing a positive therapeutic rapport

Establishing group boundaries and ground rules

Introducing some of the musical instruments in a way that facilitates mindfulness and group harmony.

Encouraging curiosity to extend sensory experiences safely without fear.

Assessing how each individual engages with others in the group, musically and verbally.

Helping each patient to develop an understanding and feel for the nature of the collaborative, reciprocal relating.

*7.2.4. Treatment Stage 2 Sessions 7-12: Emotional Regulation**Process Tools*

Jointly- created musical improvisation.

‘The Helpful Aspects of Therapy Questionnaire’. (HAT) (Ryle 2005 Version2)

Ref05/q2305/55.2005. This short questionnaire can be offered to each patient to fill in at the end of each session- also to note any unhelpful aspects of therapy.

Recognition task: R.R. Humiliating – Humiliated (past).

Sharing –Shared (present) Self-states: e.g. Dangerous state/ or ‘Out of Control State.

Traps:

1. Trying to Please.

2. Ideal Care/ Perfect Attachment Trap’

3. ‘Depressed Thinking/ Social Avoidance Trap’.

4. Music Therapists facilitate dialogues within the group and the discovering of commonalities: empathy- cognitive and affective.

Purpose of sessions:

Developing dialogical communication and listening skills

Helping each patient to gain a feel for the shared musical experience,

Encouraging patients to discover how to engage with, recognize and express their feelings musically and verbally, and with consideration for others.

Developing the ability to self-reflect.

Introducing Cognitive Mapping.

7.2.5. Treatment Stage 3 Sessions 13-18: Interpersonal Effectiveness

Process Tool: The Personality Structure Questionnaire (PSQ) Pollock, P.H., Broadbent, M., Clarke, S., Dorrian, A.J. and Ryle, A. (2001)

Builds on: Mindfulness Emotional Recognition-and Regulation, introducing the full range of instruments including Guitars and Keyboards, which involves acknowledging interpersonal dissonance.

Recognition Task

- 1.To experience Group cohesiveness. Sharing to shared
2. Dilemma, Either I try to keep things in perfect order or I make a terrible mess
3. Revision task reflecting on what it feels like to be 'good enough' or not.
- 4.To reflect on new exits: 'Who do I value?' 'What would I do differently now?'

Tolerating disharmony in music, and life: working with this metaphor to reflect safely on negative and dangerous past behaviours.

Purpose of Sessions:

Learning from each other and with the therapist through positive role modeling.

Developing each individual's range of musical self-expression: the zone of proximal development (ZPD) Ryle and Kerr 2002) develops the music therapist observes, describes and reflects on the group's thoughts, feeling and behaviours in order to raise awareness of potentially offence paralleling behaviours, and to mitigate these through recognizing and revising negative reciprocal relating through musical interaction and mapping work.

7.2.6. Treatment Stage 4: Sessions 19-24 Distress tolerance

Process Tool: The States Characterization Procedure (SCP): Ryle, A. (2007a). For supporting the reformulation of patients with borderline/ dissociative features (October 2007). Reformulation: Theory and Practice in CAT, 29, 9-11R

Recognition task: R.R. Overwhelming to Overwhelmed. Threatening to Threatened. Listening to Listened to. Frustrating to Frustrated. Self –States: Joining up states recognizing the ‘journey’ of RR s which lead to the to ‘dark state’ and how to exit it.

1.Dilemma: If I must then I will not. If I must not then I will.

2. Music Therapists work with parallel process to facilitate reflection on here and now events

3. Developing feelings of remorse and a desire to make amends

4. Managing separation anxiety and preparing for closure

uses on the ward and/or in the group, taking these into jointly created music.

Recognition of impulsivity and acceptance of frustrating to frustrated feelings.

Purpose of sessions:

Music Therapist facilitates the process of mourning, acknowledging sadness, regret, joy, connection and the ‘good enough’ real world.

7.3. Outcome Measures:

To be administered at assessment, closure and at eight weeks follow up.

Birtchnell, J. & Evans, 2004. The Persons Relating to Others Questionnaire. PROQ2 Validating Paper: *Personality and Individual differences*, 36, pp. 125-140.

Jolliffe, D. and Farrington, D.P., 2006. The Basic Empathy scale.

Validating Paper “*Development and Validation of the Basic Empathy Scale*”(BES). *Journal of Adolescence*, 29(4), pp.589-611.

Briere, J., 2002 The Multiscale Dissociation Inventory (MDI)

The Multiscale Dissociation Inventory Professional Manual. Odessa, Florida: *Psychological Assessment Resources*.

Other outcomes measures may be selected as agreed with the Patient’s overall agreed treatment objectives.

7.3.1. Music Therapy Outcome measures

The MT–PSQ Patient Satisfaction Questionnaire. Compton Dickinson, S.J. Beeley, C. and Odell-Miller, H (This measure will be further tested for validity and reliability)

The Music Interaction Rating for Schizophrenia –MIR (S) Pavlicevic, M, Trevarthton, C. Duncan, J., 2000. Improvisational Music Therapy and the Rehabilitation of Persons Suffering with Chronic Schizophrenia pp44-54 in Roberts, J.Z. 2000 *Music Therapy Research: Growing Perspectives in theory and Practice* British Society of Music Therapy BSMT Publications

7.4 Guidance for Patients

7.4.1. Mindfulness:

Learning to be mindful is common across many cultures; it is also used in various ways in many modern psychological approaches. You do not need a faith to develop your mindfulness abilities though to discover peacefulness through mindfulness techniques is common across many faiths. When you grow in mindfulness and become more aware of your impact on others, and of what you are doing it can get easier to manage your anxieties. You learn how to accept the present and to stop worrying so much about the ‘If only’ or the ‘What ifs’ in life.

In G-CAMT high intensity music therapy, instead and together as a group we discover ‘what is’.

We begin by asking a question: **what do we need to be mindful about?**

Ourselves, those around us, how we affect other people? How we feel?

You can decide on your own target aim, and you can discuss the creative challenge that you personally might like to achieve. The music therapist will help you

A mindfulness exercise:

Use as little or as much of this as feels right at any one time.

We find that we can observe what is going on both inside us and around us not only with our eyes, but with our ears and with all our senses, focusing just on one at a time.

TOUCH: We can even observe with our eyes shut, by feeling and describing the texture of the chair with our hands. Then we can quietly describe those sensations -either to ourselves or to share our experience with the group. You can choose.

HEARING We start to notice more about what is happening around us. For example: We might notice that a bird is singing, or that there is a bee buzzing in the room, or that it is raining, or we might hear an airplane or an engine running. We may notice sounds that we don't like, we learn to acknowledge those and then to let them go and leave them outside of our work.

SIGHT If we open our eyes we may notice that there is a ray of sunshine across the room, or the colour of one of the musical instruments

SMELL: can be very evocative, some of the instruments may smell of wood or fibre. This may bring back memories which may have all sorts of feelings for you. You can decide whether to share how smells affect you.

Then we think about the meaning of all these elements in how they make us feel about our individual situations right now. By becoming more aware of the present time and the vibrations of sound and colour, things can gain more personal meaning, and we can wonder where these thoughts might take us in our minds and then in our lives.

GROUNDING

If unwanted thoughts come into our head, it is important to focus on the breath and to really feel our feet on the ground, to recognize that this is not a pleasant thought- and to question if it is perhaps linked to a feeling, or if this experience was brought alive by something that someone said or did, or by something we saw or heard.

The music therapist can help you to work out whether this is an old or a new experience, whether it belongs in the here and now, or if it is from the past long gone. It may be useful to share this with the group for support, together with the music therapist to get it out on to a diagram- rather than using up your energy by keeping it secret, held in the dark. You can decide. No one will press you to tell anything that you do not want to explore. Alternately one can work musically with that feeling, to play it out by using sounds that match your feeling, instead of words. The music therapist can help you to find the sounds that feel right for you, your unique 'sound print' instrument for that day.

We learn how to be mindful of what is going on in the here and now, right at this moment in time. We are aware that we are together as a group and we think together about how safe we feel. We begin by focusing on the breath, and to marvel on how consistent our body can be, and always has been, throughout our lives, through the good, the bad and the ugly things that happened.

This might make us think about time -and then the work can begin on how we manage the difficulties of a long time or a long journey.

The music therapist can guide the group in this process. Sometimes by playing music or sometimes with words or in our minds by creative imagery, we can work as if we are on a journey together. The latest neuroscience research shows us that making our own music and being creative can stimulate our brains and help us to think straight.

CREATIVE VISUALISATION here is an example: Imagine as you settle in to your chair, first to breath in through the nose and out through the mouth, gradually relaxing your head and neck, then your arms, shoulders, back, all the way down to your feet, so that you are doing a body scan. Then imagine in your mind's eye a long, country road ahead of you and that you are looking at the sun rising slowly and brilliantly ahead of you, and that it is misty and the air is fresh, and the mist gradually melts away so that you can see the your way ahead. The mist melts away as the sun warms the land. So that we can see more clearly and be open to inspiration by hearing our own thoughts as they arise. Then we can think about our Target Aim and what each of us individually wants to achieve.

7.4.2. Emotional Recognition and Regulation: Guidance for Patients

We start by observing and describing the way we can control our own heart rate by slowing our breathing or by being more physically active and walking around when we play. We each

consider how we feel, for example: whether it was an effort to come today, and if we feel motivated or not. Each person is invited to decide whether they feel a need to calm down or to generate some energy. It is also okay also not to know how you feel, and then to ask the music therapist for help, as she will understand if you feel numbed out and she can help you to be part of the group.

We can be active and use our hands when playing the Djembe Drums together to generate energy or we can daydream and have a reverie when we play the sounding bowl to feel calm or connected. We can make angry sounds without hurting anyone, even on little hand-held instruments like the claves or the guiro, which the music therapist will show to you. We discover that in creating music together our feelings can help us. Your feelings can be like passing clouds, they will not hurt anyone when they are channeled into creating rewarding and expressive sounds together.

Sound Prints

We can start to connect to our mind with the sensations in our bodies in a different way. Each person is invited to find an instrument with which they feel comfortable; this can become your own 'sound print' which you might like to think about as becoming like your musical signature. It may be that over time you choose to go to your sound print instrument, as a familiar place, or if you feel curious about hearing the resonance and vibrations of a particular instrument, you can just observe it, describe it and take your time to decide how to explore it's potential. Your sound print can help to make you feel safe. Alternatively you might want to share your sound print and that is a way of discovering that we are all different in how music affects us because what works for you might have a different effect for the person with whom you share.

Once you have identified your sound –print, you don't have to stick to it, but all group members will gradually get to recognize each others' sound print. This is your unique resonance or vibe, your unique sound of the day and your choice. Week on week your choice might change or you might decide to keep coming back to a favourite sound . You might find yourself feeling in a different state and then you can decide to seek a new or different resonance or vibe as your sound print for that sesison- it will all depend on yourr mood and what is happening at the time for you on the ward and in your life.

The music therapist may encourage the group to choose one instrument as the group 'safety call'. The instrument selected is sometimes the free- standing cymbal, or the big Tam Tam Gong, because it can sound like an alarm call and it is easy to attract the attention of the other group members. In this way you can feel supported and safe. So that if anyone feels

overwhelmed they can hit the alarm safety call instrument and that is the signal for the group to stop. So no one needs to fear that things might get too overwhelming.

7.4.3. Interpersonal effectiveness and Conflict Resolution: Guidance for Patients

We work as a group to develop our connections with each other; by observing with our ears and eyes what each person is doing, maybe copying or answering their music. We also get feedback so we can see ourselves better and the ground rule is that we do this without judging others and we try not to judge ourselves, because this treatment is not about being good or bad, it is about finding a good enough real place in which to be with others. We might not always agree and the group may go through some stormy patches and that is okay too, because it is like real life and you will be helped to find new ways to assert yourself, to express your feelings without harm to anyone. Your process is about discovering how much light and how much darkness each person is used to in their lives, how much they would like to develop in themselves by exploring some new ways of relating to others and in yourself through how others describe your interaction with them. We think about the positives and the negatives of the dark and the light states. We start to expand our awareness in how someone else's music might affect us. We release our fears about saying how we feel, because we can just play it out and choose whether to talk or not. We get validation by the feedback from others, and we can feel valued when we give helpful feedback. This helps to create the bonds between us.

7.4.4. Distress Tolerance: Guidance for Patients

The Breath

Buddhist monks, American Indian Shamans and Mui Thai boxers have been practicing how to do mindfulness for thousands of years. It involves learning your thoughts can your impulses and the latest neuroscience proves that our minds and our bodies are connected. Our instinctive impulses are located in the oldest part of the human being: in our belly, our guts, that is the part of the human being that evolved before anything else, even before we had a brain, but it has nerves and feelings in it to help in survival instincts. That is why sometimes one can feel sick with anxiety. Our stomach is telling us about an E-MOTION which is rising up in us. So we start by focusing on our breathing then consider how our belly feels. If it is like a wobble board or full of butterflies we are gradually supported to learn how to control those fear responses by slowing the breathing.

Each person gets to know their natural instinct: whether they have a warrior instinct and the need to fight, or a runner's instinct and a desire to run away, or if they just feel frozen to the

spot. The martial arts expert knows when to fight and when to choose not to fight and that is his Art. In G-CAMT you can learn to channel these instincts in a different way, but by using the same disciplined art as that of a the yogi, the martial art expert, boxer, runner, athlete or musician. You can discover in G-CAMT when to play and when not to play and discover how to feel good about yourself as you share in this creative experiences.

The Instincts and Intuition

The instincts are our own inner hard wiring, like the hard drive of a computer, and we need to find our own mental software to manage those instincts. Our mental software is more sophisticated than our gut instinct hard drive. It is our cognitive thinking skill that is located in our brain. So to get our own hard drive and the software to communicate within each of us, as one whole individual system, we then need to switch the power on. That is like the old joke of how to get the computer to work! First plug it in, then the power and energy sets the software(your brain) to communicate to the hard drive (your. Gut feelings).

But you might wonder how? Well, that power source for each of us, lies waiting right within us, ... it is our breath and it is our breathe that can activate all the energy that runs right up and down our spinal chord. So we breathe in deeply to our belly, and we think how our lungs take in that air which we breathe and that our heart is the central organism which pumps the air around our system, to our brain, to our muscles and to all our limbs and organs. When the heart and head connect to our gut instincts we can start to connect with our intuition about what feels mindfully like the best choice of action- instead of acting on impulse. The music therapist might help you to experience this with a visualisation exercise. We consider that nothing stays the same and that as things change it may feel sad that rewarding things come to an end, or that we feel anxious about forthcoming endings and then we spend time reflecting on what we have achieved and the valuing to valued reciprocity that we have shared as a group.

Use of Instruments

The use of instruments in G-CAMT is compared to martial arts: the 'artist' in the latter always considers mindfully whether or not this is the right time to take action or to listen and wait. The musical instruments can be used mindfully with consideration of whether or not in group improvisation it feels like the right time to 'play' Thus participants learn to discern, and to choose. Impulsivity is diminished as creativity grows.